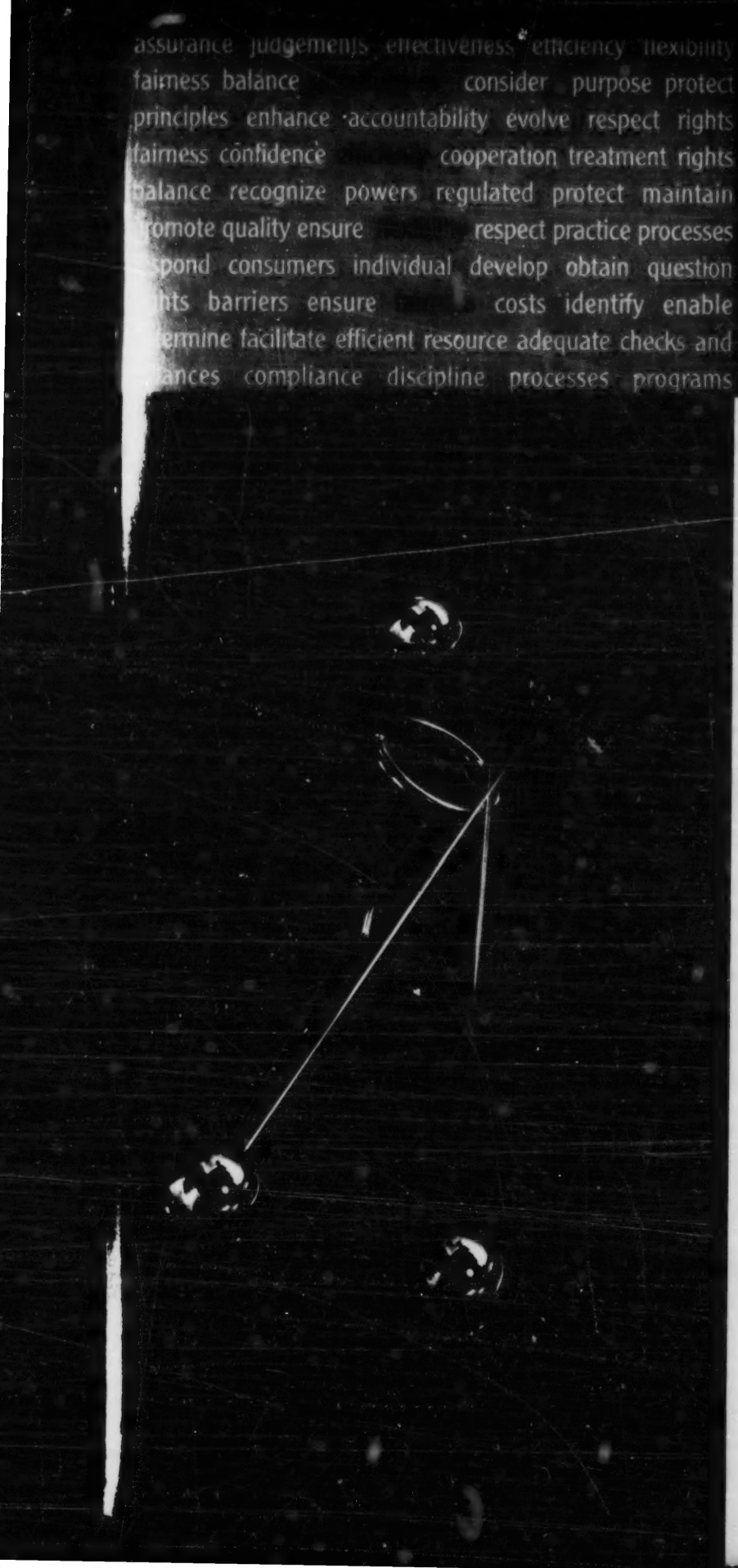
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Adjusting the Balance

A Review of the Regulated Health Professions Act

Health Professions Regulatory Advisory Council

Ontario

102-00585/

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March 14, 2001

Honourable Tony Clement
Minister of Health & Long-Term Care
Hepburn Block , 10th Flr
80 Grosvenor St
Toronto, ON M7A 2C4

Dear Minister Clement:

The Health Professions Regulatory Advisory Council is pleased to provide you with its review of the *Regulated Health Professions Act, 1991 (RHPA)*. HPRAC's mandate to review the effectiveness and impact of the *RHPA* and the health profession-specific Acts was formally articulated in 1993 with the signing of the first Memorandum of Understanding between the Minister of Health and the Advisory Council.

HPRAC's review recognizes many positive features of the legislation and, in particular, affirms two of the fundamental elements of the health professions regulatory system – self-governance of the professions and the system of controlled acts. In considering better achievement of the legislative objectives (public protection, high quality care and accountability) HPRAC recommends a series of adjustments to make the system more responsive to the public interest. Many of these adjustments are needed to give individual patients and the public better access to the health professions regulatory colleges and the full benefit of the protections expressed in the *RHPA*.

We look forward to meeting you at your earliest convenience to discuss the review findings and our advice.

Sincerely,

Rob Alder, Ph.D., Chair

Bob Morton, Vice Chair

Stephen Birch, D.Phil.

David Surplis, Ph.D.

Barry Brown, Ph.D.

Joyce Timpson, Ph.D.

Joyce Feinberg, Ph.D.

FOREWORD

One of the foundations of Ontario's health care system is health professionals who provide services to the public. In Ontario, there are approximately 220,000 regulated health professionals in 23 professions, and each of these professions is governed in accordance with the *Regulated Health Professions Act (RHPA)*. One of the key objectives of the *RHPA* is to promote the provision of high quality professional care. Thus, an effective health professions regulatory system will make a significant contribution to the quality of health care services in this province.

This document reports on a review of the effectiveness and impact of the *RHPA*. The review was a substantial undertaking, involving several years of work by staff and members of the Health Professions Regulatory Advisory Council (HPRAC). For this hard work, I thank both staff and my fellow Council members. In addition, I would like to acknowledge the work of Mary Lou Gignac who guided staff in the analyses and preparation of the report, and the expertise of Douglas Alderson who provided legal input for the entire review.

Critical to the review was the input from a broad range of stakeholders in the health professions regulatory system. The colleges, or governing bodies, for the health professions provided meaningful input on how implementation of the system is working. They provided written submissions, participated in discussion forums, and cooperated in external evaluations of several of their key programs. Input was also received from representatives of health care facilities, district health councils and health profession education institutions. Associations of health professions, unions and individual health care providers participated. Consumer advocacy groups and members of the public provided both written submissions and participated in discussion forums. On behalf of the members of HPRAC, I extend sincere gratitude to all these participants.

When the *RHPA* was passed in 1991, it represented a shift from profession-centered regulation to public interest regulation. Reference to this shift was captured in the title of the report leading to the *RHPA* with the phrase "*Striking a New Balance*". On passing this new legislation, a commitment was made by the then Minister of Health to review its effectiveness and impact. In carrying out this review, and in an attempt to reflect continuity in the development of dynamic legislation, HPRAC chose to entitle its consultation document "*Weighing the Balance*". What in fact has emerged from the review is an adjustment to the balance; hence the title of the present report, "*Adjusting the Balance*". We believe the recommendations contained in this report will lead to a regulatory system that is more effective, efficient, flexible and fair, and will well serve the interests of the people of Ontario.

Rob Alder
Chair, Health Professions Regulatory Advisory Council.

TABLE OF CONTENTS

Page

PART I OVERVIEW

Chapter 1 Introduction **1**
Overview of the *RHPA* 1
Context 2
Scope of the Review 3
Chapter 2 Methodology **4**
Chapter 3 Key Findings of the Review **10**
1. Effectiveness 10
2. Efficiency 14
3. Flexibility 15
4. Fairness 16

PART II REVIEW OF SYSTEM COMPONENTS

Chapter 4 Scope of Practice **18**
1. System of Controlled Acts 18
2. List of Controlled Acts and Who is Authorized to Perform Them 20
3. Clarity of the Controlled Acts 22
4. Routine Activities of Living Exception 30
5. The Harm Clause 33
6. Title Protection 35
Chapter 5 College Governance **41**
1. College Role and Responsibilities 41
2. College Council Structure 43
3. College Committee Structures 46
4. Public Appointees on College Councils 52
Chapter 6 Complaints and Discipline **58**
Section 1: Complaints of Professional Misconduct of a General Nature 59
1. Panel Composition 59
2. Nature of "Complaint" 60
3. Investigation Reports 63
4. Timely Disposal of a Complaint 64
5. Standard for Referral to Discipline 65
6. Powers of a Complaints Panel 66
7. Interim Suspension and Practice Limitation Orders 69
8. Appeal to the Health Professions Appeal and Review Board 71
Section 2: Discipline of Professional Misconduct of a General Nature 73
9. Power/Composition of Discipline Panels 73
10. Party Status for Complainants 74

11. Evidence 76
12. Hearing Process 77
13. Orders 78
14. Appeals 79
Section 3: Complaints and Discipline for Professional Misconduct of a Sexual Nature 80
Chapter 7 Public Access to Information 85
1. Provisions for Confidentiality of Information 85
2. Public Access to Information on the Register 88
Chapter 8 Quality of Care 93
1. Colleges' Quality Assurance Programs 93
2. Practice Setting Quality Assurance 97
Chapter 9 Patient Relations 103
Chapter 10 Roles and Responsibilities of the Minister of Health and Long-Term Care and the Health Professions Regulatory Advisory Council 107
Section 1. Role and Responsibilities of the Minister 107
1. Promoting Public Awareness 108
2. Public Education Program Content 112
3. Enforcement 113
4. Relationship between Colleges and the Ministry of Health and Long-Term Care 115
5. Oversight and Monitoring 117
6. Collection of Data for Planning Purposes 117
Section 2. Role of the Health Professions Regulatory Advisory Council 118
7. Reviews of the *RHPA* and Profession-Specific Acts 119
8. Release of HPRAC Reports 121
9. Requests for Referral to HPRAC 122
10. Program Evaluations and Ongoing Performance Monitoring 123

PART III RECOMMENDATIONS

Chapter 11 Summary List of Recommendations 125

APPENDICES

A: HPRAC'S Recommendations to the Minister on Colleges' Quality Assurance Programs
B: HPRAC'S Recommendations for Complaints and Discipline for Professional Misconduct of a Sexual Nature
C: Major Profession-Specific Issues Related to Legislation and Regulation
D: Weighing The Balance
E: Requests Related to New Controlled Acts and Authority to Perform Controlled Acts From Professions Regulated Under the *RHPA*

Chapter 1 Introduction

Overview of the *RHPA*

The *Regulated Health Professions Act, 1991,* (*RHPA*) is the outcome of almost a decade of work by the Health Professions Legislation Review (HPLR). The Review began in 1982 primarily to determine which health professions should be regulated, update the *Health Disciplines Act* and devise a new structure for all legislation governing the health professions.[1] The HPLR work culminated in proposed draft legislation – the *RHPA* and 21 profession-specific Acts.

When the *RHPA* was passed in 1991, it was widely regarded as ground-breaking legislation. Not only does it provide a common framework for the regulation of those who work in Ontario's 23 regulated health professions, it replaces exclusive scopes of practice with a system of controlled acts. Controlled acts are those procedures that, if not done correctly and by a competent person, have a high element of risk. The *RHPA* is noted for its provisions requiring each regulated health profession to have a profession-specific quality assurance program and its strong measures to prevent and deal with sexual abuse of patients by regulated health professionals. Another hallmark feature is that just under 50 percent of members on the professions' governing bodies are public appointees.

More than 220,000 people in Ontario belong to health professions governed by the *RHPA*. In addition to the common framework there is a series of profession-specific Acts that specify such things as the scope of practice of each profession, the titles reserved for each profession and the controlled acts authorized to be performed by each profession. Specifically, the *RHPA* regime consists of the *Regulated Health Professions Act*, the *Health Professions Procedural Code*, 21 profession-specific Acts, regulations under the Act and the profession-specific Acts, and the *Ministry of Health Appeal and Review Board Act*.

The *RHPA* has several objectives:

- to protect the public from harm;
- to promote high quality care;
- to make regulated health professions accountable to the public;
- to give patients/clients access to health care professions of their choice;
- to achieve regulatory equality by making all regulated health professions adhere to the same purposes and public interest principles; and
- to treat individual patients/clients and health professionals in an equitable manner.

The *RHPA* assigns duties and responsibilities to:

- the Minister of Health and Long-Term Care;
- the colleges that regulate health professions;
- the Health Professions Appeal and Review Board (HPARB); and

[1] *Striking a New Balance: A Blueprint for the Regulation of Ontario's Health Professions.*

- the Health Professions Regulatory Advisory Council (HPRAC).

The Act came into effect on December 31, 1993, and applies to 23 health professions and the 21 colleges that regulate them. The colleges are not teaching institutions, they are governing bodies. Their function is to set standards for one or more health professions and ensure they comply with the *RHPA* and the profession-specific Acts. Anyone who calls themselves a regulated health professional must be a member of the college that regulates their profession. A regulated professional is not "licensed to practice" but has a Certification of Registration issued by the college to members.

Context

In remarks to the Standing Committee on Social Development which considered the proposed legislation in August 1991, the Minister of Health indicated that the *Regulated Health Professions Act* (*RHPA*) was to be living legislation, with a process of continuous reviews and a full review in five years.

This commitment was formally expressed in 1993 with the signing of the first Memorandum of Understanding between the Minister and the Health Professions Regulatory Advisory Council (HPRAC). Under the provisions of the *RHPA*, the Minister of Health may refer any matter regarding the regulation of health professions to HPRAC for its review and recommendations. Under this authority, the Minister asked HPRAC to review the effectiveness and impact of the *RHPA* and the profession-specific Acts within five years of their enactment, which occurred on December 31, 1993. This referral is called the Review Referral.

HPRAC subsequently received two related ministerial referrals. These were requested by two members of the public, M. Arndt and B. Salvador. Both referrals were concerned with governance issues, including the composition of college councils and committees. The Arndt referral was in reference to a paper by G. Belza and raised additional issues of breach of trust, and disclosure of information. As requested by the Minister, the issues in these referrals were considered by HPRAC as part of the Review of the *RHPA* and are addressed in this Review Report.

In addition to the referral by the Minister to conduct a review of the *RHPA* five years after enactment, the *RHPA* requires HPRAC to conduct statutory evaluations of three college programs five years after enactment of the *RHPA* and to report to the Minister on the effectiveness of the programs. The programs to be evaluated are:

- quality assurance programs;
- colleges' complaints and discipline procedures for professional misconduct of a sexual nature; and
- patient relations programs.

Evaluations of the first two of these three programs have been completed at the time of writing this report, and HPRAC's recommendations were submitted to the Minister in reports dated October 2000 and December 2000 respectively. Findings from these evaluations have been

incorporated in this report on the review of the *RHPA* and their recommendations are provided as Appendices A and B. HPRAC will be submitting its evaluation report on college patient relations programs in March 2001.

Scope of the Review

This Review is designed around the question, "Has the *RHPA* generated a regulatory system that is effective, efficient, flexible and fair?"

Effectiveness of the Act was evaluated in relation to three of its key legislative objectives – protecting the public from harm, providing high quality care, and making health professionals and their governing bodies accountable for their actions.

Efficiency of the regulatory system was considered in relation to the reasonableness of the time and resources being expended, and to the administrative burden of regulation in relation to what is being achieved.

Flexibility was evaluated by determining if the regulatory system has been able to respond to emerging issues in a timely manner since, as the health care system evolves, it is essential that the *RHPA* remain flexible enough to address changes in the roles and utilization of health professionals.

Fairness was considered primarily in relation to the rights and interests of patients/clients and health professionals, as well as equality among the participants in the regulatory system.

The Review focuses on the regulatory system set out in the *RHPA* and profession-specific Acts, and on specific provisions or gaps in the *RHPA*. Profession-specific issues, such as a profession's request for an expansion of scope of practice, were not considered as part of the Review. These issues are listed in Appendix C. A review of profession-specific issues raised by a few groups is best handled through specific referrals to HPRAC by the Minister of Health and Long-Term Care. Such reviews are process-intensive and require a unique focus.

This report is organized into three parts. The first part provides an overview of the Review. The second part provides a presentation of each of the main components of the regulatory system that were selected for analysis in relation to the Review themes of effectiveness, efficiency, flexibility and fairness. The third part Chapter 11, provides a list of HPRAC's recommendations.

Chapter 2 Methodology

The *RHPA* is a broad, complex and innovative piece of legislation. Therefore, the Review required extensive preparatory discussions and planning. HPRAC undertook an extensive planning process and sought substantive input from the 21 health profession regulatory colleges on the nature, scope and possible questions for the Review and on the consultation processes.

The public consultation was designed to generate input from a wide variety of stakeholders. Consultation topics were designed to elicit information and opinions of the participants.

During 1996 and 1997, HPRAC consulted with colleges on a number of occasions. A discussion paper was sent to colleges asking for input on possible themes and issues to help guide the evaluation design and questions for the Review. The discussion paper covered several themes that HPRAC had identified in dealing with previous referrals from the Minister.

HPRAC subsequently hired a consultant to meet with the registrars of health profession regulatory colleges to identify issues encountered in implementing the *RHPA* innovations. Following these meetings a summary of the issues raised, grouped by theme, was compiled and sent to all the colleges. These issues formed the basis for further discussion on the scope and content of the Review in a workshop organized with the Federation of Health Regulatory Colleges.

In 1998, HPRAC examined the fundamental objectives of the *RHPA* and the fundamental goals of the Health Professions Legislation Review in order to develop a broad framework for this Review. From this, the following were established as guideposts for consultations:

- *Effectiveness*, which would be examined specifically with respect to protection of the public from harm, quality of care, and accountability of health professionals.
- *Efficiency*, which would be examined to determine whether the objectives of the *RHPA* are being achieved through reasonable use of time and resources, and whether the administrative burden of regulation can be streamlined without detriment to either the effectiveness, flexibility or fairness of the system.
- *Flexibility*, which would be examined to determine the ease with which the regulatory system has been able to respond to emerging issues, such as technological advancements, in a timely manner.
- *Fairness*, which would be examined in terms of sensitivity and respect for the interests and rights of all patients/clients and professionals, as well as through unimpeded access and equality among the participants in the regulatory system.

HPRAC considered three fundamental questions in determining the overall effectiveness of the regulatory system as prescribed by the *RHPA*:

- whether the *RHPA* provisions are adequate for achieving the three key legislative objectives of public protection, quality health care and accountability;

- whether colleges have been able to implement the provisions of the *RHPA* and what difficulties they have encountered, and
- what improvements are needed in legislation and in the implementation of the provisions.

In addition to these fundamental questions, HPRAC posed several supplementary questions based on the 1996 and 1997 consultations with colleges. These supplementary questions related to very specific components of the regulatory system such as the composition of College Councils, the powers of the Executive Committee, and privacy provisions for complainants and respondents.

In June 1999, HPRAC launched a broad public consultation with the publication of the *Weighing the Balance* document. *Weighing the Balance* contained general and specific questions on six themes: protection from harm, quality of care, accountability, efficiency, flexibility and fairness. Questions were designed to elicit information and opinions from the participants.

In recognition of the complexity of the *RHPA*, descriptions of its provisions relevant to each theme were included. In the appendices were the Review Referral terms of reference, listings of the 21 regulatory colleges and 13 *RHPA* controlled acts, and instructions on how to make a submission. A copy is attached as Appendix D.

Weighing the Balance invited input from those who regulate, provide and receive health care services in Ontario. This included individual patients/clients, advocacy groups, academic institutions, individual health professionals, associations of regulated and unregulated health professions, regulatory colleges and members of the general public.

Copies of *Weighing the Balance* were made available in English and French with an invitation to provide written comments on any or all of the questions. More than 6,000 copies were widely distributed from June to December 1999 through a variety of institutions and organizations, including:

- health profession regulatory colleges;
- health profession associations;
- health care associations such as consumer agencies and advocacy groups;
- hospitals;
- district health councils;
- community care access centres;
- community health centres;
- long-term care facilities;
- academic health facilities ;
- MPPs' constituency offices; and
- public libraries.

The consultation document was also posted on the HPRAC website, with an invitation to submit comments. *Weighing the Balance* informed participants that the HPRAC framework for the Review had integrated two referrals from the Minister, namely the requests from Mr. Salvador and Ms. Arndt. The two referrals were also posted on the website. A report from Mr. Belza that

formed part of the request from Ms. Arndt was also posted on the site. Participants were invited to review these materials and comment on them as well.

In addition to making *Weighing the Balance* available in both print and electronic formats, more than 32,000 brochures in English and French were widely distributed, inviting comments from patients/clients, health providers, employers and other members of the public. Participation was also invited through advertisements placed in regular and ethnic media.

A toll-free telephone number was made available for respondents outside the Greater Toronto Area. Hearing-impaired people were able to contact the HPRAC office via a TTY telephone line both locally and toll-free.

To encourage input, discussions were facilitated by 10 of the 16 district health councils between November 1999 and January 2000. During such discussions, an HPRAC member provided an overview of the *RHPA* and the review process and answered any questions that arose during discussions. Each participating district health council was responsible for facilitating the discussion and recording the positions on which there was consensus. The proceedings were then summarized as part of each district health council's Review submission.

Topics suggested by HPRAC for the district health council discussions included public education on the *RHPA*, publicly accessible information in the college registers, the current list of controlled acts, quality assurance program requirements, and the appropriate mix of public and health professionals on college councils.

The participating district health councils represented urban, rural, and northern and southern districts of Ontario. Members and affiliates of the district health councils included consumer advocacy groups, health care agencies/organizations and advisory committees for such groups as:

- general health care consumers;
- seniors/pensioners;
- children/families;
- physically disabled people;
- mental health organizations;
- health organizations/agencies for specific health concerns; and
- hospital advisory groups.

HPRAC received 368 written submissions. HPRAC acknowledges the thoughtfulness and thoroughness of the submissions received. Unfortunately, only 59 submissions were received from individual members of the public – a disappointingly low number. This may reflect a lack of knowledge of how health professionals are regulated in Ontario. Submissions were received from:

Individual health care providers	144
Associations of health care providers	64
Members of the public	59

Consumer advocacy groups	32
Regulatory colleges under the *RHPA* and Federation of Health Regulatory Colleges	22
Health care organizations	20
District health councils	12
Educational institutions	8
Unions	4
Health Professions and Review Board	1
Insurance company	1
Law firm	1
	368

Ninety percent of the people and organizations that made submissions consented to the posting of their submission on the HPRAC website. Personal identifiers in the submissions were deleted before posting on HPRAC's website in April 2000.

Comments were invited from those interested in reviewing and responding to the submissions on the HPRAC website. HPRAC accepted these comments until July 31, 2000.

All written submissions were coded and analyzed using NVivo, a software for qualitative data analysis. A number of issues emerged from the aggregated comments. Some of them, such as educational requirements for the use of titles and the design of continuing competency exams, were set aside as being profession-specific issues not covered by this review. The following elements of the *RHPA* were identified for detailed analysis. They deal with broad systems issues, potential legislative changes, and they are relevant to the effectiveness, efficiency, flexibility and fairness of the *RHPA*.

- Complaints and Discipline of a General Nature (including alternative dispute resolution, rules of evidence, transparency and party status)
- Complaints and Discipline Related to Sexual Abuse (including mandatory reporting, support services, alternative dispute resolution and funding for therapy and counselling)
- Composition of College Councils and Committees
- Controlled Acts (definitions, additional controlled acts, routine activities of living, harm clause and enforcement)
- Changes in Scopes of Practice
- Patient Relations Programs
- Public Access to Information (Section 36 Confidentiality and Information on the Register)
- Public Appointments
- Public Awareness
- Quality Assurance Programs and Practice Setting Quality Assurance
- Registration of Foreign Trained Professionals
- Role of Colleges
- Streamlining College Committee Structures
- Role of the Health Professions Appeal and Review Board
- Role of the Health Professions Regulatory Advisory Council

- Role of the Minister of Health and Long-Term Care
- Title Protection
- Unregulated Providers
- Collection of Information for Planning Purposes

Discussion groups were held with the health profession regulatory colleges on July 24 and 28, 2000. HPRAC selected topics for discussion based on their relevance to the public interest mandate of the colleges and the extent to which further college input would assist in HPRAC's consideration of the issues. Topics discussed with colleges were:

- the 120-day timely disposal of complaints;
- the use of alternative dispute resolution;
- the structure, function and powers of committees dealing with complaints, discipline and incapacity;
- the introduction of an independent body for complaints and/or discipline processes;
- the system of controlled acts; and
- the public's access to information about regulated health professionals.

Discussion groups with public representatives were held on November 21 and 23, 2000. Attendees included members of the public and consumer advocacy groups who had provided written submissions earlier in the process as well as public appointees to the regulatory colleges. These sessions provided HPRAC with an opportunity to hear first-hand the views and positions of the public on a number of key questions related to information about health professionals, protecting the public interest and accountability. Topics in the public discussions included:

- What information should a person have to make an informed choice when selecting individual health care professionals?
- What is the best way to make this information available to the people who need it?
- How can the public make sure its interest is at the centre of all decisions made by the governing bodies of the health profession regulatory colleges?
- Who should monitor the health professions' governing bodies? How?
- What information should the public receive to assure it that the colleges are doing their job in the public interest?

Summaries of the discussions with the health regulatory colleges and consumer advocacy groups were posted on the HPRAC website.

HPRAC also considered findings from the three statutory program evaluations (quality assurance, complaints and discipline related to sexual abuse and patient relations programs). These evaluations were conducted by expert consultants hired by HPRAC through a competitive process. The evaluations involved the collection of quantitative and qualitative data from colleges, college members and the public as well as the mapping of college activities against the *RHPA* requirements. In the absence of the ability to undertake a direct impact (i.e. long-term outcome) analysis to determine effectiveness, a "program logic" model approach was applied to evaluate the likely effectiveness of college activities to achieve the program objectives.

The consultation input and input from the three statutory program evaluations were carefully considered. For each element of the *RHPA* identified for in-depth review, HPRAC gave consideration to the implications of all input and examined the potential impact of all options on the regulatory system's effectiveness, efficiency, flexibility and fairness. This, along with supplemental research by staff, provided a substantive basis for the advice and recommendations being put forward in this report.

Chapter 3 Key Findings of the Review

The following chapter provides a summary of the key findings that emerged from the Review of the *RHPA*. The findings are organized around the Review themes of:

1. Effectiveness
2. Efficency
3. Flexibility
4. Fairness

At the outset, HPRAC affirms two of the fundamental elements of the health professions regulatory system as set out in the *RHPA* – self-governance of the professions and the system of controlled acts. With this affirmation firmly in place, HRPAC's review of the *RHPA* centred on making the system work better for the public of Ontario.

1. Effectiveness

The *RHPA* contains a number of mechanisms that support achievement of the three key legislative objectives of protection from harm, quality of care and accountability. Such mechanisms include the scope of practice regime; the complaints and discipline process; quality assurance programs; patient relations programs; the Health Professions Appeals and Review Board; and public members on college councils.

In HPRAC's assessment, the legislative mechanisms in the *RHPA* provide the basis for achieving an effective regulatory system for health professions. However, to maximize the effectiveness of the system, some adjustments to these mechanisms are necessary and important issues about implementation of these mechanisms need to be addressed.

Before turning to these adjustments and implementation issues, HPRAC acknowledges three particular aspects of the *RHPA* that are well supported by stakeholders as mechanisms to protect the public, promote quality services, and hold professions accountable:

System of Controlled Acts: The system of controlled acts is supported as an innovative and effective mechanism to protect the public while maintaining flexibility and people's choice of health care provider. Not one submission suggested that the system of controlled acts should be discarded or that Ontario should return to the previous system of exclusive scopes of practice. HPRAC concludes that after five years of implementation, the system of controlled acts remains a positive feature of the health professions regulatory system in Ontario.

Quality Assurance Programs: HPRAC is also highly supportive of the *RHPA* requirement for profession-specific quality assurance programs. Mandatory QA programs have served to position Ontario as a leader in health professions regulation. The comprehensiveness of most colleges' programs and the innovative approaches are commendable. QA programs have an enormous potential to keep raising the level of the quality of care provided to the people of Ontario.

Public Appointees: The health professions regulatory system is based on the concept of self-regulation and the professions have a statutory duty to regulate themselves in the public interest. The presence of public appointees on college councils and committees is an important legislated mechanism to achieve this accountability. HPRAC is highly supportive of this foundation of accountability.

This Review also concludes, however, that four shortcomings in the legislation and its implementation seriously hamper the achievement of optimal effectiveness in the regulatory system set out in the *RHPA*. These barriers are the:

- absence of public awareness about how health professionals are regulated;
- complaints and discipline processes that require strengthening;
- less than optimal transparency of college processes and outcomes; and
- lack of emphasis on the administration of the Act as exemplified in the lack of timely and ongoing orientation and support of public appointees to college councils and the general lack of enforcement of the system of controlled acts.

Public Awareness

The first major theme to emerge from the Review is lack of public awareness. Submissions received in response to *Weighing the Balance* and information from HPRAC's evaluation of the effectiveness of college's complaints and discipline procedures for professional misconduct of a sexual nature indicate a lack of public awareness about how health professionals are regulated and what professions are regulated. A survey of adults in Ontario showed that, five years after the *RHPA* came into force, only one in three people reported being certain or somewhat certain about where to file a complaint regarding sexual misconduct of a regulated health professional. The fact that, in spite of extensive outreach activities, HPRAC received only 59 submissions from members of the public reflects the low awareness of the health professions regulatory system.

Public awareness is vital if the *RHPA* system is to achieve its objectives. The complaints and discipline process cannot possibly protect the public if people do not know how to make inquiries about what is appropriate conduct for members of a profession or where to make a complaint about a health professional. Similarly, unless the public is aware of the role of the college and given information about how colleges operate, the accountability of colleges for their public interest mandate is greatly undermined.

Effective Complaints and Discipline Process

The effectiveness of the colleges' complaints and discipline process is important to achieving the legislative objectives of protecting the public from harm. It is important that the complaints and discipline process results in the appropriate actions to improve the conduct of the member and give both the profession and the public the message that substandard care and professional misconduct are not tolerated.

Many adjustments to the provisions of the *RHPA* are needed to increase the effectiveness of the complaints and discipline process and to increase the public's confidence in it. These goals are

achievable through adjustments that extend greater involvement of and support to complainants, increase the transparency of the process and the outcomes, lead to greater consistency in decision-making, and allow the college to respond quickly when a member is a serious risk to the public safety.

Some key areas for adjustment include:

- giving complainants and members an opportunity to review and comment on the recording of their statements in the investigation of their complaint;
- more explicit authority to complaints committees to refer a member for remediation or approve remediation agreements;
- guidelines for the use and limitations on the use of alternative dispute resolution;
- requirements for referring a member to discipline;
- a requirement to keep complainants and members informed of delays in a complaints process;
- expediting the interim suspension process;
- guidelines for orders at discipline;
- restricting stay on appeal of orders; and
- requirements for publishing more summary information about the results of complaints and discipline proceedings and member-specific information about cautions and remediation activities.

Transparency

The third major theme associated with effectiveness is transparency. Without a transparent system, there is no way to demonstrate accountability or move to a more open and systematic evaluation of effectiveness. Some degree of transparency is achieved through a number of *RHPA* provisions; for example, through public access to information contained on the register of members of a college, and open council meetings and discipline hearings. As with many of the positive aspects of the Act, the transparency provisions of the *RHPA* do not go far enough to be effective in achieving the legislative objectives; in this case to achieve accountability.

HPRAC has identified several areas where accountability would be made more effective through stronger legislative requirements and/or ministry policies. Some of these are:

- expanding the information available to the public about health professionals so that the public can see the results of college proceedings that result in cautions and undertakings for remediation;
- narrowing the colleges' obligation to keep information confidential so that it applies only to personal information that is not required by law to be made public (e.g. results of college proceedings should not be confidential);
- improving access to information on the college register by requiring Internet access within five years;
- requiring colleges to provide regular reports to support ongoing monitoring of college programs and requiring publication of specified information; and
- requiring the publication of all ministry evaluations of college programs.

Transparency is also an issue in relation to the principle of fairness. Apart from making available more information about the disposition of matters before a college, HPRAC recognized the need for greater transparency of decision-making criteria in dealing with complaints, the use of alternative dispute resolution (ADR) and arriving at penalties when a member is found to be guilty of professional misconduct. For this reason HPRAC makes several recommendations for the *RHPA* to be more prescriptive in these areas.

HRPAC sees these adjustments to increase transparency and accountability as critical to building the level of confidence the public has in the regulatory system.

Administration of the *RHPA*

The regulatory system has several partners with interdependent duties and responsibilities. The Minister of Health and Long-Term Care has overall responsibility to administer the Act in the public interest. The Minister's role is currently carried out through legislative, policy, oversight, and public appointment functions. HPRAC sees two major shortcomings – lack of focus on the capacity of public appointees to represent the public interest and lack of enforcement against people who are not members of regulatory colleges.

HPRAC supports the role of public appointees on college councils and committees and sees this as being critical to effective accountability. The consultation input, however, demonstrated that the effectiveness of council appointees is sometimes undermined by their poor understanding of the role of public appointees and the commitment involved when they are appointed. There is also a problem with the lack of timely orientation and ongoing training and support for them.

HPRAC concludes that public appointees must be supported to develop and maintain a higher level of capacity to represent the public interest as a balance to profession interests. This goal could be accomplished by more systematic and timely orientation and training, and the development of resources and forums to share information. HPRAC is also of the view that colleges, because of their expertise, should develop and offer training programs. In addition, HPRAC is of the view that the Minister of Health and Long-Term Care has a responsibility to ensure public appointees are selected based on knowledge and ability to represent the public interest and to support them in their important role. This is in keeping with the Minister's statutory role to administer the *RHPA* in the interest of the public and in appreciation that the public appointees are a provincial resource supporting effective accountability in the regulatory system.

Enforcement of the *RHPA* applies not only to the complaints and discipline process but also to the scope of practice regime that includes the professions' scope of practice statements, authorized acts and exceptions, harm clause, and title protection. Together with registration, the scope of practice regime is the most critical regulatory mechanism addressing the objective of public protection. It deals with preventing and handling incidents of harm and unauthorized practice.

One important means of ensuring that incidents of harm can be prevented is the successful *enforcement of provisions on practice authority*. By virtue of the *RHPA* provisions that set out fines for breaches within the scope of practice regime (performing unauthorized controlled acts, unauthorized use of protected titles and violation of the harm clause), it is clear that the legislators intended the scope of practice regime to be enforced.

Submissions to HPRAC brought to the forefront problems with enforcement. HPRAC finds that despite the central role enforcement should play in public protection, and the adequacy of enforcement provisions in the *RHPA*, neither the Ministry of Health and Long-Term Care nor the colleges appear to be enforcing the Act with regard to unregulated care providers. This lack of enforcement of the *RHPA* remains a stumbling block to its effectiveness.

HPRAC recognizes that no one stakeholder can effectively enforce the *RHPA*. A recognized partnership between the minister/ministry, colleges and the public is essential if enforcement is to be a practical reality. Failing cooperation between these main stakeholders, enforcement will remain problematic.

2. Efficiency

It is important that the *RHPA* requirements, in particular the administrative requirements, are neither unnecessarily cumbersome nor excessively burdensome, that the required procedures are streamlined as much as possible, and that colleges operate in an efficient and timely manner. And this should be so without compromising the desired outcomes. Efficiency is essentially about achieving objectives through the best use of opportunities and resources.

HPRAC acknowledges the high costs associated with regulating health professions – on the part of both the professional members and the Ministry of Health and Long-Term Care. The costs and administrative burden are especially noted in relation to colleges with small memberships. HPRAC is of the view, however, that the regulatory obligations placed on a profession and its regulatory body are appropriate in spite of the costs. To sacrifice some elements of the regulatory system would result in less effectiveness or fairness.

The submissions did not reveal pressing efficiency issues apart from concerns about the time it takes for colleges to handle complaints, for HPARB reviews and for the ministry to process regulations. Throughout the Review, however, HPRAC found opportunity for greater efficiency through streamlining the college committee structure.

Streamlining College Committee Structure

The current system allows for the fragmentation of information and the duplication of some functions. To achieve greater administrative efficiency, HPRAC has concluded that some college committee functions should be merged to create a complaints/screening committee and single adjudicative committee.

First, with respect to complaints, HPRAC concludes that there is much merit in merging some Executive Committee functions with the Complaints Committee to create a single

complaints/screening committee that would receive information about a member from any source and make the appropriate disposition. Greater structural and/or administrative efficiency can result in greater accountability, as HPRAC found evident through the Health Professions Appeal and Review Board becoming more accountable because of improvements it has made to its administrative process.

Second, with respect to adjudication, HPRAC concludes that the current Discipline Committee and Fitness to Practise Committee should be merged into a single adjudicative committee called the Professional Conduct Committee. This recognizes the high level of commonality in process and duplication of function.

The findings of the evaluation of college patient relations programs indicate that the requirement for colleges to have a dedicated Patient Relations Committee is unnecessary and is potentially a barrier to comprehensive and integrated patient relations programming. HPRAC supports greater flexibility for colleges and recommends replacing the requirement for a statutory Patient Relations Committee with a statutory requirement for colleges to coordinate the patient relations programs across the college to better achieve the program objectives.

HPRAC supports maintaining the statutory committees for executive, quality assurance and registration functions in addition to the merged committees for complaints/screening and adjudication.

3. Flexibility

In *Weighing the Balance*, HPRAC noted that changing environments, technologies and social realities require the *RHPA* to provide a flexible framework that can respond to the changing practice contexts of health professions. Just as the previous system for regulating health professions under the *Health Disciplines Act*, *Drugless Practitioners Act* and other Acts became obsolete, so too will the *RHPA* and profession-specific Acts if they do not have sufficient flexibility to respond to an ever-changing health care environment.

The *RHPA* sets out a framework that allows for focused changes in profession-specific legislation and regulation. The scope of practice regime with its system of controlled acts, authorized through profession-specific legislative components, provides a sufficiently flexible model for regulating health professions. Legislative amendments can be made, and indeed have been made, to expand professions' scopes of practice; similarly, regulations that give definition or set limits on controlled acts authorized to a profession have been amended to respond to changing needs.

Regular Reviews of Legislation

HPRAC maintains that for optimal flexibility, however, there should be a system of regular reviews of the profession-specific Acts. Such reviews will capitalize on the flexibility that is available in the current legislative framework and will serve to ensure the legislation is responsive to changing professional, technological and environmental factors. The reviews

of profession-specific Acts must be based on public interest criteria and support public participation in the review process.

4. Fairness

In *Weighing the Balance* HPRAC noted that "fairness" is exemplified by the degree to which individuals are treated with sensitivity and respect, procedural rights are respected, and people have access to health care professions of their choice. Fairness also deals with the balance of the rights and powers of colleges, health professionals and members of the public.

HPRAC supports the concept of an "umbrella" legislation that sets out common regulatory structures and requirements for the 23 regulated health professions and their 21 regulatory colleges. To a great extent, the common framework promotes equitable and fair treatment of the public and health professionals across the system. Information about the common structures and requirements as set out in the *RHPA* can be conveyed more readily to the public because they do not differ from college to college or profession to profession.

The detailed procedural safeguards provided in the *RHPA* are necessary and, for the most part, balance the rights of the complainants, members and the college as well as satisfy the rules of natural justice. Where HPRAC has made recommendations to enhance the transparency of process and the role of the complainant, it was careful to maintain this balance and recognize procedural safeguards to both complainants and members. An example of this recognition is the extension to both complainants and members of the right to review the investigator's recording of their statements.

Fairness in the Complaints and Discipline Process

Participants in the consultation discussed fairness most often in the context of the complaints and discipline process. In particular, from the complainants' and the members' perspectives there were many comments indicating serious reservations about the fairness and integrity of the process. Members of the public believe that colleges tend to protect their members while some members of the colleges are inclined to believe that colleges do not adequately protect them.

HPRAC found through the submissions and evaluation of colleges' complaints and discipline process related to sexual abuse that a minority of people with concerns about the conduct of a health professional actually submit a complaint to the college. People must be encouraged and supported to come forward to the colleges with their concerns. In many ways, colleges rely on this source of information to take the necessary actions to deal with the members of the profession and protect the public from harm.

The effectiveness of the complaints and discipline process is dependent on having the confidence and trust of the public and individual patients/clients who have a concern about the behaviour of regulated health professionals. The *RHPA* represented a paradigm shift from profession-centred regulation to public interest regulation. Adjustments to the college procedures are needed to recognize and support the role played by individual complainants and secure the objectives of the shift.

HPRAC is of the view that perceptions of fairness are essential to public confidence in colleges' complaints and discipline processes. The willingness of complainants to come forward and proceed with a complaint depends on the confidence they have in colleges' handling of complaints in a fair and sensitive manner.

While the provisions in the *RHPA* are intended to ensure procedural fairness, HPRAC maintains that there needs to be greater sensitivity and respect for complainants, as well as opportunity for greater involvement by complainants in the proceedings. Increased support for complainants in cases of alleged sexual abuse would move in this direction. Party status for all complainants in the discipline process would also move in this direction. Demonstration of a fair complaints and discipline process is also achievable through greater transparency of outcomes as mentioned earlier. Accordingly, a number of recommendations have been made that seek to increase fairness in the complaints and discipline process through recognition of the important role complainants play in the system.

HPRAC concludes that the increased support for and involvement of the complainant in the complaints and discipline process, together with the restriction on use of ADR, the requirements for referral to discipline and the increased disclosure provisions mentioned earlier, will have the effect of increasing the number of complaints going to discipline. This in HPRAC's view will address to some extent the concerns expressed in the submissions by a number of participants.

Conclusion: Adjusting the Balance

At the outset of HPRAC's review of the *RHPA*, it undertook to answer the fundamental question of whether the Act has achieved an appropriate balance between its key legislative objectives (public protection, quality care and accountability) and its effect on efficiency, flexibility and fairness. HPRAC has found that to a remarkable degree the *RHPA* has achieved a good balance in the regulation of health professions in Ontario in a relatively short time. However, the balance needs to be adjusted in a number of areas for the system to be truly effective, efficient, flexible and fair.

When the *Health Disciplines Act* and other profession-specific Acts were replaced by the *RHPA*, there occurred a clear paradigm shift in the manner and mode of health profession regulation in Ontario. The paradigm of profession-centred regulation gave way to public interest regulation. The *RHPA* is a more transparent and publicly accountable form of regulation than its predecessor. However, in HPRAC's view, the balance struck with the *RHPA* requires additional adjustment in favour of greater transparency and accountability and in favour of supporting greater awareness and involvement of patients and the public. The result, a more effective system of health profession regulation, will serve the people of Ontario well into the 21st century.

Chapter 4 Scope of Practice

This chapter focuses on the scope of practice model, which includes the controlled acts and their exemptions and exceptions, the harm clause and title protection. It is organized as follows:

1. System of Controlled Acts
2. List of Controlled Acts and Who is Authorized to Perform Them
3. Clarity of the Controlled Acts
4. Routine Activities of Living Exception
5. The Harm Clause
6. Title Protection

One of the central organizing concepts of the health professions regulatory system under the *Regulated Health Professions Act* is the replacement of monopolistic[2] or exclusive scopes of practice with a system of controlled acts. These controlled acts can be authorized to two or more professions where their scopes overlap. In the previous system, anyone who was not licensed in specific professions was prohibited from practising within the scope of practice of those professions. This fundamental change to the system was designed to introduce greater flexibility in who delivers health care services while still protecting people from harm.

To promote freedom of choice of health professions for consumers, the *RHPA* leaves much health care activity in the public domain. In fact, this aspect of the Act is considered groundbreaking. Other jurisdictions have looked to Ontario's system as a model when amending or enacting health profession legislation.

1. System of Controlled Acts

The *RHPA* lists 13 procedures that, if not done by a competent person, have a high or significant element of risk. These "controlled acts" include such activities as communicating a diagnosis, setting or casting a broken bone, prescribing drugs and delivering babies. The *RHPA* stipulates that no one can perform a controlled act unless the law that applies to his or her own health profession clearly allows him or her to do so.[3] Health care services not involving a controlled act are in the public domain and may be performed by anyone.

The *RHPA* permits a regulated health professional whose profession has been authorized to perform a controlled act to delegate the performance of that act to someone else. The delegation can be to a regulated health professional whose profession is not authorized to perform the controlled act or to an unregulated person. Such delegation must be in accordance with the profession's regulation where one exists.[4]

There are also a number of exceptions to the prohibition against an unregulated person performing a controlled act. For example, a person can give first aid or temporary assistance in

[2] The term "monopolistic scopes of practice" was used by the Health Professions Legislation Review in *Striking a New Balance*.
[3] Subsection 27 (1) of the *RHPA*.
[4] Subsection 28 (1) and (2) of the *RHPA*.

an emergency, or a student can perform controlled acts within the scope of his or her future profession if the acts are done under the direction and supervision of a member of the profession.[5]

There are also exemptions to the controlled acts system set out in a regulation under the *RHPA*. The regulation permits the performance of such acts as acupuncture, ear or body piercing, electrolysis and tattooing for cosmetic purposes.[6]

Consultation Input

One of the more notable findings to emerge from HPRAC's consultation process was the fact that no submissions suggested that the *RHPA* controlled acts system should be discarded or that Ontario should return to the previous system of monopolistic or exclusive scopes of practice.

HPRAC Analysis

The Health Professions Legislation Review[7] explained the rationale for the controlled acts approach as follows: "The model we recommend is based on the principle that the sole purpose of professional regulation is to protect the public interest. We believe that regulation of scope of practice is necessary because it is evident that some of the activities performed by health care providers pose a risk of harm if unqualified persons perform them. However, it is equally true that some health care services are not intrinsically hazardous. We believe that the public should have freedom to choose the caregivers from whom it obtains those services that are not unduly hazardous. We believe that the existing regulatory model – both in principle and how it has been applied – inadequately protects the public. Moreover, we believe it has undesirable effects on the health care system. In particular, it discourages flexibility and resists innovation in the provision of health services." [8]

HPRAC also notes that British Columbia and Alberta have incorporated the concept of controlled or reserved acts into their new health profession legislation and finds that the system of controlled acts achieves a good balance between enabling access to health professions of choice and protecting the public from harm.

Submissions from the consultation process confirm this view. It is HPRAC's opinion, based on all the information before it, that the basic concept of the controlled acts system is a good one and should remain a central concept of the *RHPA*. However, it is important to increase the public's awareness of this system and to ensure that the system remains valid and effective. To achieve this goal, it is necessary for the controlled acts system to be flexible in order to reflect

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[5] Subsections 29 (1)(a) and 29 (1)(b) of the *RHPA*.
[6] Section 8, Ontario Regulation 107/96 under the *RHPA*.
[7] The Minister of Health for Ontario announced the creation of the Health Professions Legislation Review in November 1982. The HPLR mandate was to make recommendations to the Minister in the form of draft legislation, with respect to:
- which health professions should be regulated;
- updating and reforming the *Health Disciplines Act*;
- devising a new structure for all legislation governing the health professions; and
- settling outstanding issues involving several professions.

[8] *Striking a New Balance: A Blueprint for the Regulation of Ontario's Health Professions* (Government of Ontario, 1989), pp. 13 – 14.

current practice and the current state of technology and innovation in the health care system. There must therefore be mechanisms in place for keeping the public informed and for keeping the system current.

HPRAC also notes that the controlled act provisions are undermined by ambiguous enforcement provisions and a lack of public education on this fundamental aspect of the regulatory system. The issues of the currency of the controlled acts and scopes of practice, public education and enforcement are discussed in Chapter 10 on Roles and Responsibilities.

Some submissions from the regulatory colleges noted the need for the ministry to have a clear policy on the delegation of controlled acts. HPRAC did not undertake a full analysis of the concerns and options for a delegation policy. This was in recognition of the extensive work already done by colleges through the Federation of Health Regulatory Colleges and the input this has generated for the ministry's policy work. HPRAC appreciates the need for a delegation policy, especially to articulate the accountability in delegation.

2. List of Controlled Acts and Who is Authorized to Perform Them

Consultation Input

A number of respondents suggested that the list of controlled acts should be expanded to capture other activities they felt posed a significant risk of harm to the public. There were also many submissions from health professional groups and colleges requesting authority to perform controlled acts that are currently not authorized to them. These specific requests are summarized in Appendix E. Fifteen of the 23 health professions regulated under the *RHPA* requested an expansion of their scope of practice to perform additional controlled acts. Nine new controlled acts were also proposed. Some professions proposed adding additional elements to existing controlled acts; e.g. adding laser to the controlled act regarding applying forms of energy.

Because of a particular concern about risk of harm to the public, HPRAC notes here the specific requests to regulate psychotherapy and the prescription of therapeutic diets and of enteral and parenteral feeding.

Many of the submissions – including those of several district health councils and health organizations, a number of individual health providers, the Psychiatric Patient Advocate Office, the College of Psychologists, the Ontario Psychological Association, and a member of the public – requested that psychotherapy be added to the list of controlled acts. The primary reason given was that psychotherapy may be harmful to the public if not provided by an appropriately trained person. For instance, one health professional commented on the possible adverse consequences of misapplication of psychotherapy techniques for recovering memories of childhood sexual abuse.

The College of Dietitians of Ontario and the Dietitians of Canada requested that prescription of therapeutic diets and of enteral and parenteral nutrition feedings/solutions be added to the list of controlled acts so that the list covers the full range of procedures that can cause significant risk of harm.

The Ontario Massage Therapist Association recommended that there be a mechanism within the *RHPA* to review the controlled acts on a periodic basis and determine whether additional controlled acts are needed.

HPRAC Analysis

As indicated, many professions asked that additional procedures be regulated as controlled acts and that members of their profession be authorized to perform them. HPRAC considered such requests to be beyond the scope of this review. Within the current structure of the *RHPA*, however, the professions can ask the Minister of Health and Long-Term Care to refer the issue of additional controlled acts to HPRAC. Such requests for reviews would provide for the analysis and evaluation of evidence on the "significance" of the risk associated with the activity in order to determine the need for addition to the list and authorization to a profession or professions.

Consultation input from a variety of sources suggests that authorizing some professions to perform additional controlled acts may be appropriate in light of the perceived risk of harm associated with the activity. HPRAC considers this to be particular relevant to the request to regulate psychotherapy and prescribing enteral and parenteral feeding.

The College of Dietitians of Ontario asked that the prescription of therapeutic diets and prescription of enteral and parenteral nutrition be added to the list of controlled acts. It submitted that the prescription of therapeutic diets requires special education and training and carries significant risk of harm when performed by untrained people. The college also cited evidence of the health problems resulting from inappropriate prescription of enteral and parenteral nutrition. HPRAC also notes that dietitians work to a large extent in the community and authorizing the prescription of enteral and parenteral nutrition would appear to improve access to those who require it.

HPRAC notes that several participants suggested psychotherapists should be regulated and that psychotherapy should be made a controlled act given the potential for harm to the public by those who do not have adequate training. HPRAC recognizes that psychotherapy done properly is a highly complex form of treatment and that this complexity requires corresponding expertise and skilled application of knowledge. The misapplication or misuse of psychotherapy can have serious adverse effects on consumers.

The *RHPA* focuses almost exclusively on physical risks. However, the risk of sexual/emotional/mental harm to patients must also be given due consideration. HPRAC concludes therefore that regulation of psychotherapists and/or making psychotherapy a controlled act should be reviewed with reference to the nature and extent of associated risk of emotional harm.

HPRAC asserts that regular reviews of the list of controlled acts and profession-specific authorized acts would ensure that the system remains efficient and flexible. With the advances in technology and knowledge in the health care system, there is a need to ensure that procedures harmful to the public are added to the list of controlled acts and that acts no longer harmful

because of advances are removed from the list. Professions evolve as technology changes and their body of knowledge increases. As a result, it is natural for a profession to request additional controlled acts. A mechanism to make appropriate adjustments to the scope of practice of professions based on an assessment of risks and benefits would add needed flexibility to the *RHPA* system. This matter is discussed further in Chapter 10 in relation to the future roles and responsibilities of HPRAC (pages 119-121).

HPRAC Recommendation(s)

1. **That periodic/scheduled reviews of profession-specific Acts be used as a means of considering whether to add new authorized acts or remove existing ones, in addition to the current mechanism through which the Minister of Health and Long-Term Care makes referrals to HPRAC of a specific request for expansion of a profession's scope of practice (see also recommendation #61 in Chapter 10 on Roles and Responsibilities, page 121).**

2. **That the Minister invite (a) a request for a referral from the College of Dietitians of Ontario on amending the *RHPA* to list the additional controlled act of prescription of therapeutic diets and prescription of enteral and parenteral nutrition, and (b) invite a request for a referral from appropriate psychotherapy groups on amending the *RHPA* to list the additional controlled act of psychotherapy.**

3. Clarity of the Controlled Acts

Thirteen controlled acts are listed in the *RHPA*. Clarity and consistent interpretation are important only to the extent necessary to effectively regulate the health professions and clearly indicate what can and cannot be done by unauthorized providers. Given the simple/concise expression of the controlled acts, it is understandable that the 23 professions regulated under the *RHPA* vary to some extent in how they interpret some of the controlled acts.

- In some instances, professions understand and use the various terms incorporated into the controlled acts somewhat differently.
- The concepts expressed by some terms, such as diagnosis, are complex in nature.
- There are some overlapping meanings; e.g. the label of a symptom can also be a diagnosis, as with tendonitis (inflamed tendon).
- Legal opinion supports the tradition that, if ambiguous, the words are presumed to be used in the manner in which health professions understand them.[9]

Several different professions have authority to perform some controlled acts, such as communicating a diagnosis. Having different interpretations of the same controlled act may or may not interfere with regulation and public protection.

A profession can utilize several existing mechanisms when a definition becomes problematic. A college can ask the Ministry of Health and Long-Term Care to clarify the definition (this has not

[9] College of Physicians and Surgeons of Ontario v. Larsen (1987), 45 D.L.R. (4th) 700 (Ont. H.C.J.).

been effective in the past), go to court to ask for an interpretation or ask the Minister to refer the issue to HPRAC.

Consultation Input

Regulatory colleges submitted the majority of comments concerning controlled acts. They agreed that the *RHPA* should clearly define the controlled acts to ensure consistent interpretation across colleges and professions. They noted that problems of definition occur when certain terms are used in legislation but are not defined. Colleges' interpretation of the terms sometimes results in the same terms being used differently. Specific mention was made of the following terms:

- "communicating a diagnosis"
- "disorder" and "dysfunction"
- "drug" and "substance"
- "prescribing" and "administering"
- "hearing aid prescription"

These issues are discussed below.

Communicating a Diagnosis

The first controlled act set out in the *RHPA* is "communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis."[10]

There are three parts to this controlled act:

1. Someone must communicate to the person (the patient) or his or her personal representative.
2. A diagnosis identifying a disease or disorder as the **cause of symptoms** of the person must be what is communicated [emphasis added].
3. It must be reasonably foreseeable that the person or his or her personal representative will rely on the diagnosis.

Communicating a diagnosis as expressed above does not include assessing or labelling the signs and symptoms a person may present with. The underlying cause of the symptoms, if it is a disease or disorder, is what must be communicated to the patient. A diagnosis involves the ability to identify a disease or disorder by drawing a conclusion based upon certain knowledge and skill. It is the conclusion itself which is the diagnosis and not the procedures upon which the conclusion is based. The act of communicating a diagnosis is clearly not the same as the act of making a diagnosis. However, the controlled act of communicating a diagnosis requires that it is foreseeable a patient would rely on the diagnosis, perhaps to the extent of subjecting him/herself to invasive treatment. Thus it is understood that the performance of the controlled act would

[10] Subsection 27 (2) 1. of the *RHPA*.

require the authorized health professional to have the competencies to also make a diagnosis, or to validate a diagnosis made by another health professional.

In other words, to label or validate with some confidence the disease or disorder causing the symptoms, health professionals communicating a diagnosis to someone who is going to rely on this information must engage themselves in the cognitive process of reviewing the assessment findings and drawing a conclusion based on the body of knowledge and science of their profession.

Consultation Input

Only seven of the 23 regulated health professions (physicians, podiatrists, chiropractors, dentists, optometrists, psychologists, and registered nurses in the extended class) are authorized to perform the controlled act of communicating a diagnosis. Physicians technically have unlimited diagnostic authority while psychologists, for example, have boundaries or limitations on what conditions or disorders they can communicate; e.g. they may only "communicate a diagnosis as the cause of a person's symptoms, a neuropsychological disorder or a psychologically based psychotic, neurotic or personality disorder." A number of consultation participants requested that their profession(s) be authorized to communicate a diagnosis.

Many respondents stated that the controlled act of communicating a diagnosis is not well understood. For example, the Ontario Podiatric Medical Association asked, "what is the difference between a 'diagnosis' and an 'assessment'?" The College of Audiologists and Speech-Language Pathologists of Ontario said that the determination of whether a disease or disorder is being communicated to a patient is difficult to make, and that confusion arises when professional terminology communicated in one profession's context is interpreted in another profession's context.

The College of Dental Hygienists of Ontario said the use of the word "diagnosis" is probably one of the most misunderstood elements of the controlled acts model. The Ontario Society of Occupational Therapists stated that, although its college has offered guidelines, the interpretation of this act continues to confuse and restrict occupational therapists.

Some respondents also said that it is difficult to obtain informed consent without communicating a diagnosis. The College of Physiotherapists of Ontario stated that the issue is problematic for health care professionals not permitted to communicate a diagnosis when they attempt to obtain informed consent for the treatment options they propose to their patients.

Models Used in Other Jurisdictions

In British Columbia, the health professions legislation lists "reserved acts" similar to Ontario's controlled acts. In that province, however, the reserved act is "making a diagnosis" instead of "communicating a diagnosis."

In Alberta, the list of "restricted activities" is also similar to Ontario's list of controlled acts but neither making nor communicating a diagnosis is included in the list of restricted activities in the

province's *Health Professions Act*. Alberta decided that restricting diagnosis would offer little protection over and above the other restricted activities defined in its legislation. The working group that discussed this issue stated it was not possible to develop a meaningful or useful definition of diagnosis that would apply to all health care providers. It concluded that diagnosis was implicitly included within the performance of each proposed restricted activity and, in that context, is already addressed. The group also said that if diagnosis were restricted, virtually all health care providers would have to be regulated.

HPRAC Analysis

During Standing Committee[11] discussions, legal counsel for the Ministry of Health and Long-Term Care explained why the Health Professions Legislation Review decided to use the term "communicating a diagnosis" instead "making a diagnosis," as is the case in B.C. Those conducting the review, she said, looked at the risks associated with diagnosis from the practitioners' point of view. When most practitioners think of diagnosis, they think of the information-gathering process, and the application of diagnostic tests and procedures. Then they think of the cognitive process whereby they subject the information they have collected to a thought process, organize and study that information, apply their judgment to it, then transform it into an entity that is communicated to the patient.

The Health Professions Legislation Review held that the part of the process whereby information is gathered – such as the performance of diagnostic tests, some of which may be hazardous – would probably be covered by other controlled acts or covered by other legislation. As a result, those who took part in the Health Professions Legislation Review determined that "it was impossible and inadvisable and silly to contemplate controlling the thought process in any way." This led them to designate, as the controlled act, the actual communication of the product of all this effort, which is telling the patient what is wrong with him or her.[12] HPRAC has noted above that communicating a diagnosis is a knowledge-driven process.

The Standing Committee discussions also help explain the difference between "diagnosis" and "assessment." Legal counsel for the ministry stated that the Health Professions Legislation Review (HPLR) used the word "assessment" to mean something that all regulated providers could engage in. Since that was something different than diagnosis, they included the word "assessment" in the scope of practice statements of most regulated professions and gave it a particular definition.

By including the definition of assessment and the word "assessment" in these individual health profession Acts, the HLPR intended to signal that even if health professionals could not perform the controlled act of communicating a diagnosis, they could nevertheless perform an assessment and communicate the results of the assessment to their patients.

[11] The Standing Committee on Social Development (a committee of the Legislature) held public hearings on the draft RHPA and profession-specific Acts.
[12] Hansard, August 7, 1991, S-278.

From this discussion, it is clear to HPRAC that – as long as the legislation states only certain professions can communicate a diagnosis – anyone else can assess a patient and communicate the results of the assessment.

On the issue of informed consent, HPRAC is of the view that, in many instances, a patient can consent to treatments based on findings of an assessment that deal with signs and symptoms without necessarily needing to know the label of the disease or disorder that causes them. A great deal of information can be conveyed to a patient as a result of an assessment, including an explanation of what is causing the signs or symptoms, as long as it is not the labelling of a disease or disorder.

If labelling (i.e., a diagnosis) is needed for informed consent, a consultation with a health professional who has authority to communicate a diagnosis may be most appropriate. In addition, if the lack of authority to communicate a diagnosis is significantly impeding a profession from delivering high quality care, it would be appropriate for that profession to formally request an expansion of scope of practice to include that controlled act.

Finally, HPRAC agrees with the Health Professions Legislation Review logic as to why "communicating a diagnosis" was chosen as the controlled act and does not think it should be changed to "making a diagnosis."

Disorder and Dysfunction

Nine professions have scope of practice statements that include wording related to the treatment and/or prevention and/or diagnosis of disease/disorder/dysfunction.

Consultation Input

One college submitted that the difference between "disorder" and "dysfunction" is confusing.

HPRAC Analysis

At the Cabinet committee considering the *RHPA*, the ministry's legal counsel stated that "the Health Professions Legislation Review did not propose recommendations that would have defined dysfunction and disorder." [13]

HPRAC notes that the need to define "disorder" and "dysfunction" was considered before proclamation of the *RHPA* and a decision was made not to define these terms. HPRAC questions the need for a system-wide definition that would result in a very general and vague description of these terms, rather than asking regulatory colleges to define them within their particular profession. Profession-specific clarity of the terms acknowledges the different cultures of professions and the specific terminologies used by them.

A college can provide greater clarity for its members by providing definitions related to the specific disorders or dysfunctions dealt with by that profession. The college can also differentiate

[13] Hansard, August 6, 1991, S-257.

how these are different from signs and symptoms. HPRAC does not believe that the consultation provided sufficient evidence to require the definition of these words in legislation. In addition, HPRAC is of the view that there is no particular benefit to the public or patients in having a common cross-profession definition.

Drug and Substance

Consultation Input

The College of Physiotherapists of Ontario said there is a lack of clarity about the meaning of certain undefined terms used in the controlled acts. It noted that problems arise when different colleges and agencies interpret these undefined words to mean different things. The college stated that the lack of such clarification undermines the protection to the public accruing from the controlled acts model.

From the college's perspective, one of the key areas needing clarification is in the difference between "drugs" and "substances." The college notes that in Section 27 (2) 8 of the *RHPA*, drugs are defined through the use of the *Drug and Pharmacies Regulation Act*. However, in Section 27 (2) 5 nothing indicates what constitutes a substance. The college submits that some colleges have taken the position that drugs and substances are similar. Other colleges suggest that substances include a much broader range of agents than just drugs. For the College of Physiotherapists, one specific problem relates to the use of oxygen. The Federation of Health Regulatory Colleges of Ontario also asked whether substance refers to drugs or is more inclusive.

HPRAC Analysis

Controlled act 5 is "administering a substance by injection or inhalation." HPRAC has obtained a legal opinion that "substance" is a broad term and would be understood by a court in its plain and ordinary meaning. Therefore substance includes "drug" as well as non-drugs such as saline and glucose and gases such as oxygen. In HPRAC's view this controlled act does not require clarification. If a college is authorized the controlled act of administering a substance by injection or inhalation, its members can administer either a drug or a non-drug.

Prescribing and Administering

Consultation Input

The College of Physiotherapists of Ontario further noted that some colleges consider "prescribing" and "administering" to be much the same, while others do not. For the College of Physiotherapists, the problem relates to oxygen. The question is whether a change to the rate of flow of oxygen provided to a patient is a prescription or a change in the administration of the agent. The Federation of Health Regulatory Colleges of Ontario also asked whether "administer" is the same as "prescribe" or broader.

HPRAC Analysis

Neither "prescribing" nor "administering" is defined in the *RHPA*. The discussions of the Cabinet committee that considered the *RHPA* do not appear to reference these particular words. In British Columbia, "prescribing" is defined in the context of the reserved act of "prescribing, compounding, dispensing or administering by any means a drug." It is defined as "the ordering of a drug." It is also similarly defined in the reserved act of "prescribing appliances or devices for vision, hearing or dental conditions" and in "ordering the fabrication or alteration of appliances or devices for vision, hearing, or dental conditions."

HPRAC maintains that these definitions do not add much more meaning to what is currently in the *RHPA*. "Administering" is not defined in British Columbia. Neither "prescribing" nor "administering" is defined in Alberta's legislation.

HPRAC is of the view that "prescribing" is clearly different from "administering." Prescribing involves determining what needs to be prescribed, whether it is a particular medication or a particular strength of eyeglasses, and ordering it. Administering does not involve a determination of "what" but instead involves giving something that has already been decided upon.

Richard Steinecke, author of *A Complete Guide to the RHPA*, cites several court cases to demonstrate that, where there is ambiguity in wording, the meaning of the words are to be understood as the profession in question understands them.[14] Therefore, the words "prescribing" and "administering" take on the meaning of how they are understood in the professions that have controlled acts for prescribing and/or administering.

HPRAC concludes that these terms do not need to be defined to protect the public. Professions can provide their members with interpretation guidelines that clarify what the term means in a profession-specific context. When there is intra-professional or inter-professional disagreement on a particular term, existing mechanisms can be utilized to obtain interpretation.

Prescription of Hearing Aids

Consultation Input

A few respondents found controlled act 10, "prescribing a hearing aid for a hearing impaired person," to be particularly problematic. The question asked is "What constitutes a prescription for a hearing aid?"

HPRAC Analysis

How a hearing aid can be prescribed was discussed at Standing Committee. A physician could make a determination of how specific he or she is going to be on the prescription and whether further testing was required. In other words, a prescription may be very generic. A person could either:

[14] Steinecke, *A Guide to the RHPA*, p. 11-3.

- take a generic prescription prepared by a physician to a hearing aid dispenser who could test the person's hearing and then dispense the appropriate hearing aid; or
- go to an audiologist who would be able to test the person's hearing more fully and prepare a much more detailed prescription than a physician would.[15]

The discussions at Standing Committee demonstrate that the intent was for the legislation to be flexible enough to allow either a generic or a specific prescription to be issued. Therefore, HPRAC is of the view that it is unnecessary to further define this controlled act. HPRAC was not presented with any evidence that suggests the public is being harmed as a result of the current controlled act for prescription of a hearing aid. If the public were to be harmed as a result of the flexible language, HPRAC would reconsider its position.

The College of Audiologists and Speech-Language Pathologists of Ontario provides its members with preferred practice guidelines for the prescription of hearing aids. The college's submission noted that its guidelines may not be consistent with those of other regulatory colleges, unregulated providers and ministry funding programs. HPRAC nonetheless concludes that it is not necessary to resolve such inconsistencies by amending the *RHPA* to clarify the definition of "prescribing a hearing aid." It suggests that this matter should be resolved between the college and the relevant ministry programs.

The essence of a controlled act is something that carries with it a significant risk of harm if not done by a qualified person. At the heart of the issue for consideration by HPRAC is whether the harm associated with prescribing a hearing aid is significant enough for it to be a controlled act. If all it entails is simply referring a patient to either an unregulated or a regulated provider for a hearing test to determine specifications, it would not appear to entail significant enough physical risk to warrant being considered a controlled act.

If, however, the risk is in specifying the requirements of a hearing aid, this activity is currently not regulated through the system of controlled acts. For the most part, it is done by hearing aid dispensers – members of an unregulated profession. It is not within the scope of this review to determine what should be a controlled act. Such a determination should be based on a more comprehensive analysis of the risks involved.

HPRAC Recommendation(s)

3. **That the Minister of Health and Long-Term Care refer to HPRAC the question of whether, in consideration of evidence of risk, the simple determination of a need for a hearing aid should be a controlled act, or whether determining the specifications for a hearing aid, based on a hearing test and an assessment of the physical aspects of the ear, should be the controlled act.**

[15] Hansard, August 6, 1991, S-255.

4. Routine Activities of Living Exception

Subsection 29 (1) of the *RHPA* lists exceptions to the system of controlled acts. One such exception is that a person who is not a regulated health professional may perform certain controlled acts if he or she is assisting a person with the routine activities of living. The specific controlled acts allowed under this exception are administering a substance by injection, and putting an instrument, hand or finger beyond the external ear canal, beyond the point in the nasal passages where they normally narrow, beyond the larynx, beyond the opening of the urethra, beyond the labia majora, and beyond the anal verge or into an artificial opening into the body.[16]

Routine activities of living that involve these controlled acts include giving insulin injections, inserting and removing an indwelling catheter, and tracheostomy suctioning.

Consultation Input

The routine activities of living exception was discussed by 20 advocacy groups representing people with disabilities, two associations representing nurses, the College of Nurses of Ontario, Cheshire Homes of London Inc. and the Ontario Community Support Association, an attendant service organization.

Consumer advocacy groups and members of the public strongly defend the exception for routine activities of living. For them, the exception is essential to ensure that consumers of attendant services continue to have the independence to live in their communities, choice of care providers, and control over the quality of care they receive. Without this exception, these consumers believe they would live restricted and dependent lives with increased risk to their physical and mental health.

These groups and individuals believe that quality of care for routine activities of living is assured because consumers control and direct the attendants who perform these activities. The groups stated that quality care is compromised by professionals who follow the guidelines established by their regulatory colleges when performing these routine activities, instead of adapting to the specific needs and preferences of the consumer receiving the care.

They pointed out that the consumer of attendant services is the knowledgeable person who does the training, knows the needs, takes the responsibility and directs the actions to be taken, and to whom the performer of the service is accountable. Mechanisms for quality and control in reducing risk in attendant services have nothing to do with "professional accountability, standards and qualifications" but everything to do with the controls inherent in the relationship between consumer and attendant.[17]

Three of the 20 consumer advocacy groups also stated the need for clear guidelines to establish when it is appropriate and safe for controlled acts to become routine activities of living.

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[16] Subsection 29 (1) (e) of the *RHPA*.
[17] Submission of the Centre for Independent Living in Toronto.

However, these recommendations for guidelines must always contain statements that emphasize clients' rights to control their activities of daily living and thus maintain independent lives.

Consumer advocacy groups are concerned that increased intervention by health professionals will threaten the independence of persons with disabilities. They are also concerned that the College of Nurses of Ontario or other colleges governing health professionals will be given too much authority to direct and monitor the routine activities of living and decide which "specific clients" are eligible for the exception. In addition, they raised concerns about increased financial and resource costs if the activities of daily living exception were eliminated.

The College of Nurses of Ontario and the associations representing nurses noted that the exception was intended for independent, permanently disabled people who required intimate care to support daily living. They expressed concern that the exception is being used inappropriately as a least-cost delivery option for more and more people with varying care needs. The associations were also concerned that unregulated workers are increasingly providing "nursing" care without the necessary judgment, skills and knowledge to assess consumers' conditions. The Ontario Community Support Association was also concerned that unregulated workers are increasingly performing nursing services.

The College of Nurses recommended modifying the activities of daily living exception for unregulated providers under the controlled acts and risk of harm provisions. It recommended that the exception apply only when the client or substitute decision-maker is able to understand, provide input to and monitor the care that is provided and is thus able to direct the caregiver. The college suggested that:

- The activities of daily living exception for controlled acts be limited to situations where an unregulated provider is trained in the procedure by a regulated health professional.
- The performance of the procedure is limited to specific clients.
- There are clear mechanisms for monitoring the performance of the provider by a regulated health professional.
- There are clear mechanisms for appropriate monitoring of the clinical condition of the client by a regulated health professional.

The Registered Practical Nurses Association of Ontario noted that the term "routine activities of living" is not defined in the *RHPA*. The effect of the exception is to allow unregulated care providers to perform the specified controlled acts without direct supervision, adequate training or monitoring. The association said that this is unacceptable as it exposes people, especially those who may be vulnerable, to risk of serious harm.[18]

The Registered Nurses Association of Ontario recommended strengthening the criteria by which the activities of living exemption can be applied.

[18] Submission of the Registered Practical Nurses Association.

Several consumer advocacy groups responded to the submission from the College of Nurses. Their submissions stated that the college's recommendations represented a threat to the independence of persons with disabilities.

No specific evidence of harm or poor quality care resulting from the exception was reported in the submissions.

HPRAC Analysis

On the international, national and local level, the community of adults with physical disabilities has worked to gain independence from institutions and from being treated as "patients" within the health care system. In Ontario, this community fought hard for this exception under the *RHPA*.

The exception for routine activities of living relates to the *RHPA* principles of flexibility, quality of care and protection from harm. As previously noted, the College of Nurses is concerned that the exception is being applied too broadly and that unregulated providers are providing care to people who cannot direct their own care. The college believes that quality of care is being undermined by the principle of flexibility.

HPRAC is of the view that flexibility in applying the legislation is important, but that it cannot come at the expense of quality care or protection from harm. On the other hand, there is a danger in being overly prescriptive in the application of the exception and losing the flexibility that people require for their care needs.

Adults with physical disabilities, as health care consumers, are affected by this exception. Those who use attendant services at home, in supportive living units, and in some facilities, often "direct" their own personal care. There is no legal definition of "direct," but it generally means that the person instructs his or her attendant about what is to be done, when it is to be done, and how it is to be done. There are also situations where attendants provide care for people with disabilities who are unable to direct their own care because they cannot communicate instructions or lack the cognitive ability to do so.

The exception allows attendants to perform certain controlled acts without a nurse or other regulated health professional delegating the specific act to them. There is no requirement for a nurse or other regulated health professional to train or supervise them. In fact, supervision is carried out by the recipient of the attendant service or by a service agency.

HPRAC notes that this exception is not limited to situations where the person receiving the care is also directing it. Providers sometimes use the exception to perform controlled acts for people who do not direct their own care, and this occurs in both community and facility settings. This care is not necessarily supervised or guided by nurses or other regulated health professionals. Most often, people are not given a choice about whether a regulated or unregulated professional will be providing the care that involves a controlled act that falls under the exception.

HPRAC is also mindful of an employer's responsibility to a patient in relation to quality of care. Flexibility in the *RHPA* should not be lost to compensate for a lack of standards of care in facilities or community service agencies. By virtue of funding relationship, many employers are subject to service standards set by the Ministries of Health and Long-Term Care and Community and Social Services. Greater use of standards and monitoring of outcomes could be employed to ensure appropriate application of the exception and make sure quality of care is not compromised. HPRAC acknowledges the special challenges related to the care provided to vulnerable people in unlicensed/private settings such as rest and retirement homes.

HPRAC is of the view that removal of the exception would represent a fundamental change to current practices. Removal would increase the role of nurses in performing controlled acts that assist people with routine activities of living and/or in delegating the performance of such controlled acts. Nurses would also have a greater role in assessing patients/clients and monitoring the delivery of personal care services. Removal of the exception for routine activities of living would reduce flexibility in the system and increase costs. It would raise the demand for nurses at a time when there are shortages.

An amendment to the *RHPA* to restrict the exception to situations where adults direct their personal care would likely address the perceived concerns presented by nurses without taking away the autonomy of those directing their own care. However, it would be a challenge to clearly define the meaning of "directing" one's own personal care. The exception needs to be applied more broadly, beyond people who direct their own care but who at a minimum understand and consent to the application of the exception.

HPRAC Recommendation(s)

4. **That the exception for routine activities of living be maintained but the *RHPA* be amended to specify that the exception applies only where the person receiving the care or his/her substitute decision-maker provides informed and explicit consent to the application of the exception.**

5. The Harm Clause

The purpose of the harm clause is to cover those potentially dangerous activities that may not be specifically prohibited by the controlled acts scheme. This clause in the *RHPA* prohibits a person from treating or advising someone about his or her health in circumstances when it is reasonably foreseeable that **serious physical harm** may result (emphasis added).[19] Exemptions to the harm clause are also set out for:

- people acting under the direction of or in collaboration with a member;
- a person to whom a controlled act was delegated;
- **counselling about emotional, social, educational or spiritual matters** (emphasis added);
- rendering first aid;

[19] Subsection 30 (1) of the *RHPA*.

- fulfilling the requirements to become a member of a health profession regulatory college;
- treatment by spiritual means;
- treating a member of one's household; and
- assisting with routine activities of living.[20]

Consultation Input

Many colleges have recommended that the *RHPA* be amended to broaden the harm clause to include emotional, psychological and financial harm. Because the provisions of the harm clause are currently limited to "serious physical harm," consultation respondents are concerned that the clause is too narrow to provide sufficient protection from harm. There is also a concern that the clause, because of the word "serious," sets too high a standard to have any practical effect.

HPRAC Analysis

Protecting the public from harm is of utmost importance. In fact, it is the foundation on which the *RHPA* was created. Patients/clients and members of the general public cannot be sufficiently protected unless the *RHPA* contains adequate provisions for achieving this outcome and regulatory colleges put them into practical effect. The harm clause is one of the provisions intended to protect the public. It is also one of the few provisions in the Act that applies to unregulated practitioners and the general public as well as to regulated health professionals acting outside their scope of practice.

An exemption provides that the harm clause does not apply to counselling about emotional, social and educational or spiritual matters. HPRAC is convinced by the arguments presented in the submissions that counselling about emotional matters can be harmful. The harm clause should apply. This is especially relevant given the number of unregulated practitioners providing counselling services.

HPRAC is not aware of any investigation or court action by colleges using this provision. They do not currently use the harm clause to deal with unregulated providers or members acting outside their scope of practice. Colleges state that the provision is too narrow and the burden of proof they must meet too high. HPRAC is of the view that "serious" is too high a threshold to be met and supports lowering the burden of proof.

The harm clause may be of greater effect in preventing harm if the enforcement provisions of the *RHPA* are strengthened. Further discussion on this issue is found in Chapter 10 on Roles and Responsibilities, section 1(3), page 113.

HPRAC Recommendation(s)

5. **That Section 30(1) of the *RHPA* be amended to add the element of psychological harm.**
6. **That Section 30(1) of the *RHPA* be amended to remove the word "serious."**

[20] Subsection 30 (2)-(5) of the *RHPA*.

7. That Subsection 30(4) be amended to remove the word "emotional" from the exemption for counselling.

6. Title Protection

Protecting the titles of regulated health professionals is an important aspect of the regulatory system. The purpose is to allow people to identify and differentiate between regulated health professionals and unregulated providers. It is one of several things that aid in describing a regulated health profession. Others that aid public understanding are:

- scope of practice, which describes what a profession can do;
- authorized acts, which describe the controlled acts a particular profession can perform;
- governance, by a specific regulatory college.

The majority of respondents expressed a concern that the title protection provisions of the *RHPA* are inadequate and the enforcement provisions ineffective. The following discusses the various aspects of title protection contained in the *RHPA*:

- "Registered" and "Regulated"
- Holding Out Clause
- "College" Title

"Registered" and "Regulated"

Consultation Input

A few respondents said that unregulated health care practitioners use the word "registered" even though they are not members of a regulatory college. The College of Dietitians of Ontario said that this practice is misleading to the public because it implies registration with a recognized statutory regulatory body. The college noted that Alberta's *Health Professions Act* addresses this issue by preventing someone who is not a regulated health professional from using the word "registered" or "regulated." The Alberta Act states that:

> "No person or group of persons shall use the word 'registered' or 'regulated' or the phrase 'regulated health professional' alone or in combination with other words in a manner that states or implies that the person is a regulated member unless the person or group of persons
>
> **a)** is a regulated member or consists of a group of regulated members, or
>
> **b)** is a person or group of persons authorized to use the word 'registered' or 'regulated' or the phrase 'regulated health professional' in connection with the health service by another enactment." [21]

[21] Subsection 128 (10) of the *Health Professions Act*.

HPRAC Analysis

HPRAC acknowledges the provisions in Alberta's *Health Professions Act* dealing with protection of the words "registered" and "regulated." HPRAC also notes the reserved titles that the B.C. Health Professions Council has recommended for certain professions. In its review of the profession of physiotherapy, the B.C. council recommended that the titles "physiotherapist" and "physical therapist" be reserved for members of the college. It stated that its practice was to not use the term "registered" for members of self-regulating colleges under the *Health Professions Act* because the regulatory scheme embodied in the Act is not a "registration" system.

The B.C. council also stated that it had been its practice to reserve a descriptive term, such as "physical therapist," for exclusive use of members of the college, so that the use of the term "registered" was unnecessary. However, in the council's review of massage therapy it stated that the term "registered" would be helpful to distinguish members of the college from unregulated practitioners. Council also suggested the term "registered" for registered nurses as there was an overriding public interest in retaining terms that derive from long-term usage.

HPRAC supports protecting "regulated" and "registered" as well as the words "licensed" and "certified" because these words can be used to imply regulation. HPRAC also maintains that this must be done in conjunction with public education. These provisions will be effective only if public education about the *RHPA* is enhanced and the public is made aware of all the protected titles in the legislation.

HPRAC Recommendation(s)

8. That the *RHPA* be amended to prevent someone who is not a regulated health professional from using the words "registered," "regulated," "licensed" or "certified" in the course of providing health care.

This provision should not *require* all regulated health professionals to include these words in their protected title (e.g. "registered doctor" or "licensed doctor") but it should prohibit a person from using the words "registered," "regulated," "licensed" or "certified" unless he or she is a regulated health professional or permitted to do so by other legislation. However to increase public recognition of the regulated health professions, the term "regulated" should be encouraged.

Holding Out Clause

The profession-specific Acts as part of the *RHPA* contain provisions on restricted titles and representations of qualifications (holding out). For example, s. 9 (1) of the *Medical Technology Act, 1991* provides that no person other than a member shall use the title "medical laboratory technologist," a variation or abbreviation or an equivalent in another language. Subsection 9(2) provides that no person other than a member shall hold himself or herself out as a person

qualified to practice in Ontario as a medical laboratory technologist or in a specialty of medical laboratory technology.

The *Psychology Act, 1991* has a provision on protection of terms related to title that none of the other profession-specific Acts contain. This provision stipulates, in s. 8.(3), that a person who is not a member contravenes s.8 (2) (representation of qualifications) if he or she uses the word "psychology" or "psychological," an abbreviation or an equivalent in another language in any title or designation or in any description of services offered or provided.

Consultation Input

The Federation of Health Regulatory Colleges of Ontario noted that "the *RHPA* and the profession-specific Acts generally do not restrict unregulated practitioners from describing their activities by using words that are very similar to the protected titles of regulated professionals." The Federation of Health Regulatory Colleges noted that "a member of the College of Physiotherapists of Ontario may use the title 'physiotherapist' or 'physical therapist' but anyone can claim to offer physiotherapy." As a result, "this can lead to public confusion when consumers wrongly assume that they are receiving physiotherapy from a regulated professional" and causes problems for the consumer who wishes to lodge a complaint.

The Federation of Health Regulatory Colleges recommended that "in the representation of qualifications section of each profession-specific Act, reference be made to the membership of the profession *and* the practice of the profession." It further recommended that "practitioners who are not regulated health professionals should be prohibited from representing their services as being those of a regulated health professional through the use of words, abbreviations, descriptions or equivalents in another language."

Other respondents also recommended that the holding out provision be expanded to refer to the discipline description and that this description be similar to that in the *Psychology Act, 1991.*

The issue of the holding out clause/discipline description was addressed by 25 submissions, including 10 from regulatory colleges and seven from professional associations. The College of Dietitians of Ontario said the holding out clause "is inadequate in protecting the public from false claims about a person's qualifications. It only prevents non-members from holding themselves out to be qualified to practice as a dietitian in Ontario, but it does not prohibit them from making claims that they are qualified to perform the same nutrition care activities that dietitians are qualified to perform."

The college suggested that the holding out clause be amended to read, "No person other than a member shall hold himself or herself out as a person who is qualified to practice as a dietitian or to practice dietetics."

Similarly, the College of Chiropodists of Ontario recommended that the holding out provision in the *Chiropody Act, 1991* be amended to refer to both the qualification to practice as a chiropodist or podiatrist and the qualification to practice chiropody or podiatry, and to prohibit the use of the words "podiatric" or "chiropodial" in any description of services offered or provided.

The Ontario Podiatric Medical Association recollected that "the Health Professions Legislation Review exercise concluded that protection of discipline descriptions was inadvisable because some of those descriptors had become entrenched in commonplace usage. Accordingly, to protect such descriptions would, first, be difficult to enforce and, second, if enforced would extend the regulated professions' monopoly into the unregulated sector and the public domain."

However, the association stated that "the lack of protection of discipline descriptions exposes the public to an undue risk of harm" and that "the potential to mislead the public is too real and great to be countenanced any longer."

HPRAC Analysis

As a legal concept, "holding out" is related to issues of representation and fraud. A prohibition against it simply means that individuals or corporations cannot represent themselves as being something they are not. In the *RHPA*, it is membership in a profession and the qualifications thereto that are protected from being misrepresented.

At the Standing Committee hearings, Alan Schwartz (Chair of the Health Professions Legislation Review) was asked about the arguments raised by a number of submitters over the issue of title protection. For example, the committee had heard from a speech-language pathologist that the term "speech therapy" is common usage and that failure to protect the title of "speech therapy" would create confusion in people's minds and in many ways subvert the intent of the legislation. Psychologists and physiotherapists presented similar arguments.

Mr. Schwartz stated that the protection of fewer titles would make it easier for the public to make the connection between the regulated health professional and his or her protected title. In other words, it will be easier to identify the title with who can use it. He also argued that many people want generic protections of words in order to have economic monopolies.

During the hearings, Bill 63, *An Act respecting the Regulation of the Profession of Psychology*, was amended. One of the amendments was to add the following subsection:

(2.1) "A person who is not a member contravenes subsection (2) if he or she uses the words 'psychology' or 'psychological,' an abbreviation or an equivalent in another language in any title or designation or in any description of services offered or provided." The parliamentary assistant to the Minister of Health and Long-Term Care explained this amendment by stating that it continued the protection that was in the former Act.

As an example of protection of discipline description, if "physiotherapy services" were protected, a kinesiologist would be prevented from stating or advertising that he or she provides physiotherapy services. HPRAC questions whether adding discipline descriptions to the title protection provisions increases protection of the public in a meaningful way or whether there are other ways of increasing protection.

Chapter 10, section 1(2), pages 112-113 deals with the issue of public education. As will be discussed in that chapter, the public is not well informed about the *RHPA* and the health regulatory scheme in Ontario. Protection could be increased if a public education campaign raised the issue of title protection and set out all the protected titles for health professionals who are regulated under the *RHPA*. In HPRAC's view the onus is on regulated health professions to promote the significance of receiving services from a regulated health professional rather than an unregulated one. In addition, protection can be increased by enforcement of the title protection provisions of the *RHPA* and profession-specific Acts.

HPRAC is also of the opinion that adding a discipline description (e.g. physiotherapy) to the title protection provisions would essentially prohibit a person from promoting services she or he is legally allowed to provide. This would be taking a large step backwards to the system of licensed monopolistic scopes of practice. As the consultation feedback indicated, the controlled acts system is a good one and HPRAC supports the *RHPA* objectives of flexibility in who delivers health care services and freedom in choosing health care providers. Therefore, HPRAC does not see a need to amend the *RHPA* in this regard.

College Title

Subsection 34 (1) of the *RHPA* stipulates that, "No corporation shall falsely hold itself out as a body that regulates, under statutory authority, individuals who provide health care. No individual shall hold himself or herself out as a member, employee or agent of a body that the individual falsely represents as or knows is falsely represented as regulating, under statutory authority, individuals who provide health care."

HPRAC Analysis

In Alberta, the *Health Professions Act* sets out the provisions on title protection. Two provisions deal with the use of the word "college":

- "No person or group of persons shall use the name of a college, alone or in combination with other words, in a manner that states or implies that the person or group of persons is a college under this Act unless the person or group of persons is a college under this Act." [22]

- "No corporation shall use the word college, alone or in combination with other words, in a manner that states or implies that the corporation is a college under this Act unless the corporation is a college under this Act or authorized to use the word college under another enactment." [23]

Currently in Ontario, a corporation can use the word "college." The Ministry of Education consults with the Ministry of Health and Long-Term Care when an entity asks if it can use the word. The latter ministry typically assents to the use of "college" but only because there is no precedent or statutory authority to deny such use.

[22] Subsection 128 (2) of the *Health Professions Act*.
[23] Subsection 128 (6) of the *Health Professions Act*.

The *RHPA* addresses the issue of a corporation "holding itself out" as a health profession regulatory college but does not address the use of the word "college." HPRAC has some concern about the use of the term "college" for voluntary regulatory bodies because it creates confusion and misleads the public. If the Ministry of Health and Long-Term Care wants tools to deny use of the word "college," the *RHPA* should be amended to prohibit such use.

HPRAC Recommendation(s)

9. **That the *RHPA* be amended to include a provision that no corporation, association or individuals shall use the word college, alone or in combination with other words, in a manner that states or implies that the corporation, association or individual is a college under the *RHPA* unless the corporation, association or individual is a college under the *RHPA* or authorized to use the word college under another enactment.**

Enforcement of the Scope of Practice Model

As indicated earlier, HPRAC is of the view that the scope of practice model is a good one but that its enforcement provisions need to be improved for the system to be effective. Enforcement is dealt with in Chapter 10 on Roles and Responsibilities, section 1(3), pages 113-115.

Chapter 5 College Governance

This chapter looks at how colleges and their committees are structured and the roles and responsibilities of the colleges. Two separate ministerial referrals made to HPRAC on behalf of members of the public were concerned about governance issues. How governance is set out in the *RHPA* is central to effective and efficient self-regulation of health professions in Ontario. The *RHPA* designates the structure and composition of college councils and committees as well as the powers each of them has.

This chapter examines the following aspects of governance:

1. College Role and Responsibilities
2. College Council Structure
3. College Committee Structures
4. Public Appointees on College Councils

1. College Role and Responsibilities

The *RHPA* specifies objectives for the health profession regulatory colleges. Some of these are:

- to regulate the practice of the profession and to govern members in accordance with the *RHPA* and related regulations and by-laws;
- to develop and maintain qualification standards for their members;
- to develop and maintain programs and standards of practice that assure quality care;
- to develop and maintain standards of knowledge and skill and programs that promote continuing competence among their members;
- to develop and maintain standards of professional ethics for their members; and
- to assist individuals to exercise their rights under the *RHPA*.

The collective focus of these purposes is to maintain and improve the overall performance of health professionals and to achieve better outcomes for their patients/clients.

Consultation Input

College Powers

The comments on college powers were equivocal. Participants felt that college powers were either adequate or excessive.

Only one college, that of the Medical Laboratory Technologists of Ontario, commented on college powers and felt that they were adequate. Four associations also felt the powers were adequate to protect the public (Ontario Psychological Association, Ontario Dental Hygienists'

Association, Dietitians of Canada and the Ontario Association of Optometrists). One health professional and one member of the public stated that college powers were adequate.

Four health professionals indicated that the colleges' powers were excessive, as did three professional associations (the Ontario Society of Physicians for Complementary Medicine, the Canadian Society of Respiratory Therapists and the Ontario Society of Medical Technicians). The Ontario Society of Physicians for Complementary Medicine in particular claimed that the colleges' powers were excessive, as evidenced by "protracted investigations, the lack of disclosure and delay in opportunities for judicial reviews and appeals."

Rights of Members

The primary responsibility of a health profession regulatory college is to govern the profession in the public interest by making sure its members comply with professional standards and legal obligations expressed in the regulations of the *RHPA*.

Some submissions stated that few provisions in the *RHPA* apply to college members, with the exception of procedural provisions on college proceedings to handle complaints, discipline and incapacity matters. Individual health professionals indicated that there is too little emphasis on the rights of members in college processes, especially complaints and discipline.

Six associations felt that college members' input into the development of policies, by-laws and regulations is not given appropriate consideration. These include the Ontario Society of Chiropodists, the Ontario Psychological Association, the Vision Council of Canada, the Ontario Society of Medical Technologists, the Canadian Society of Respiratory Therapists, and Respiratory Therapists for Positive Change. Many argued that colleges have no obligation to consider members' input and often choose to disregard it. They asked for an explicit provision in the *RHPA* to require colleges to consider and respect the input of members into the development of policies, by-laws and regulations. The Simcoe-York District Health Council also felt that colleges provide too little support for their members.

HPRAC Analysis

The issues of college powers and members' rights relate primarily to the *RHPA* principles of accountability and fairness.

Few comments were made on college powers and HPRAC does not find that they provide a compelling argument for changes to the current provisions. The comments of those who felt college powers were excessive may indicate difficulties colleges have had in implementing the procedural requirements of the *RHPA* rather than their having excessive powers; e.g. the length of time colleges took to implement procedures and deal with complaints.

Comments on members' rights related primarily to the lack of input sought by colleges on policies and practices that affect members. Colleges clearly have the mandate to assist their members. Section 3 (1) (6) of the *RHPA* states that they should "develop, establish and maintain programs to assist individuals to exercise their rights under this code and the *RHPA*."

Furthermore, colleges currently have the authority to provide supports to members for various college proceedings. The *RHPA* provides for disclosure of information and safeguards for members in the complaints and discipline processes. These issues are further explored in Chapter 7 on disclosure of information to the public, as well as in HPRAC's report to the Minister on colleges' complaints and discipline procedures for professional misconduct of a sexual nature.

Under the *Red Tape Reduction Act*, the *RHPA* was amended with the intent of requiring colleges to consult with their members on the development of college by-laws and regulations. Subsections 94 (2) and 95 (1) (1.4) clearly state that by-laws and regulations (with certain exceptions) shall not be made unless they are circulated to every member at least 60 days before the college council approves them. It should be noted that many colleges provide fax-back services so that their members can provide comments quickly.

The mandate of colleges is clearly stated within the *RHPA*. They are to govern the profession in the public interest. At times, the reasons for the decisions made by college councils may be unclear to the members of the profession. Colleges have the difficult task of safeguarding the public interest where their members and the professional association may have strong professional interests.

HPRAC concludes that the powers of the colleges are appropriate as expressed in the *RHPA* and that the rights of members are adequate to maintain a balanced system.

2. College Council Structure

The composition of each college council is set out in the profession-specific Acts. Most of these Acts set out narrow ranges for both elected professional members and public appointees of college councils. Other Acts specify precise numbers for elected professional members and public appointees. Some Acts also provide for the selection of education representatives. The accepted policy is that elected professional members would outnumber public appointees by one or two positions. However, where the Act provides for education representatives, the public appointees are further outnumbered.

The *RHPA* sets out the requirements for the composition of the statutory committees and committee panels. These provisions ensure that elected members have a slight majority; for example, three of five or two of three on a panel. However, given the ranges stated in many profession-specific Acts, it is technically possible for a college council to have more public appointees than elected professional members. Government appointments can be adjusted to ensure elected members remain a majority.

In the document *Striking a New Balance*, the Health Professions Legislation Review recommended that college councils be composed of one-third public appointees and two-thirds elected professional members. The government of the day chose to increase the balance of public appointees. In appreciation of the "self-governance" model for regulating health professionals in Ontario, the proportion of public appointees on a college council was increased to just under half.

The *RHPA* does not prohibit public appointees from holding executive office or chairing any of the statutory committees. In practice, there are many instances where public appointees are elected to office, including the office of president.

Consultation Input

In the consultation document *Weighing the Balance,* HPRAC requested public comment on:

- the appropriate mix of public appointees and health professionals on college councils;
- whether the majority of college council members should continue to be health professionals elected by their colleagues; or
- whether there should be greater regulatory control placed in the hands of public members.

Participants who addressed this issue disagreed on the professional/public mix on college councils. Some said councils should have a majority of professional members, a composition necessary for cost efficiency, self-regulation and an understanding of profession-specific issues. This group included mainly individual health providers, professional associations and a few colleges.

Other participants stated that a balance of professional and public members is necessary to ensure both accountability and professional knowledge. This group is more diverse, including some colleges, a few associations and individual health providers, the Federation of Regulatory Colleges of Ontario, some district health councils and a member of the public.

Yet another view is that health professions should not be self-governed and public representatives should be in the majority on college councils. This view is usually associated with a belief that self-governance is not working in the public interest and/or increasing public representation will result in greater accountability to the public. These respondents included mainly consumer advocacy groups, such as the Queen Street Patients Council, Toronto Health Coalition and Psychiatric Patient Advocate Office, as well as one member of the public. This view was also put forward by Mr. Belza in his paper, which formed part of the request from Ms. Arndt that was referred to HPRAC by the Minister.

Some associations suggested including representatives from other sectors, such as student and academic members. An association suggested increasing representation of francophones on college council and committees. Three professional associations recommended that members of the corresponding professional association be represented on councils.

A number of participants, including colleges, stated that representation on college councils by members of other professional groups was an interesting idea that would increase accountability and encourage both diversity and the exchange of information and ideas among related professions. Other respondents stated that such representation would be confusing and have a negative impact on self-regulation.

HPRAC Analysis

HPRAC considered the following in determining the appropriate mix of elected professional members and appointed public members on college councils:

- impact of increasing public appointments on the model of self-governance;
- evidence to indicate the need for a move away from self-governance;
- alternative models of governance;
- anticipated impact on college governance and decisions;
- alternative ways to increase accountability of college councils, and
- alternative ways to strengthen the public representation on college councils (e.g. public member education to increase the quality of participation).

Ontario is in the forefront with respect to the proportion of public appointees on governing bodies. Its regulatory system for health professions already has very high public involvement in the governance of the professions – with public members just under the majority on college councils, with public members on all statutory college committees and public members eligible to hold executive office.

HPRAC is not persuaded of the need to move away from professional self-regulation. HPRAC maintains that the desired outcome is increased accountability for governing the profession in the interest of the public and better public representation on college councils. This can be achieved through methods other than changing the mix of elected and appointed members and moving away from self-regulation. Larger gains may be realized through such alternatives as education and other supports for public appointees, greater use of program evaluations, standardized and more regular reporting, and stronger oversight. These possibilities are discussed in the later section on public appointees (page 52) and in Chapter 10 (page 117).

Increasing the proportion of public appointees on college councils to a majority can be viewed as ending self-governance of the regulated health professions. College officials have often said that council votes are not split along the lines of public vs. professional members. Some people also said that public members get "co-opted" by professional members. It is unlikely that these dynamics would change simply by increasing the number of public appointees.

Thus, contrary to the view put forward by Mr. Belza, HPRAC concludes that giving public appointees a majority on college councils will not necessarily increase public accountability. In addition, members of a profession would be left with financial liability and no authority. Unless other aspects of the regulatory system are changed, such as the role of the Minister and Ministry of Health and Long-Term Care, there is a risk of having "the public" responsible for the governance of the professions without the appropriate supports. Having a majority of public appointees would necessitate a different role for the ministry because the government would ultimately have an increased responsibility to ensure the effective governance of the professions and regulatory bodies through its public appointees.

HPRAC therefore affirms self-governance of health professions in Ontario and maintains that there should be a majority of professional members, with public members just under the majority. HPRAC recommendations seek to uphold self-governance in the health regulatory system by keeping professional members in the majority.

Current provisions in the profession-specific Acts do not protect the mix of professional and public members – in some instances, it is technically possible for appointed public members to outnumber elected professional members. This situation should be rectified to protect a slight majority of elected members and preserve self-governance. At the same time, some colleges may want to look at the number of their council members to ensure they have enough to carry the workload of the committees – the current numbers were determined over ten years ago. Many colleges have changed in size and complexity of membership, and some colleges are now re considering the number of council members needed to effectively carry out their statutory obligations. HPRAC also recognizes the importance of effective linkages between colleges and professional schools through the schools' representation on college councils.

HPRAC Recommendation(s)

10. **That a provision be added in each profession-specific Act to ensure elected professional members have a majority of at least one and no more than two over public appointees. This amendment could be done with reference to specific numbers for elected and appointed members in the profession-specific Acts or as an additional provision indicating that the number of elected members must equal the number of public appointees plus one but not more than two.**
11. **That the Minister take advantage of the proposed legislation changes to consult with colleges about their need to increase or decrease the total number of council members and to add a statutory provision to include council members from professional schools.**

3. College Committee Structures

Currently under the *RHPA*, colleges are corporate entities that have their governance structures prescribed in the *Health Professions Procedural Code* (*HPPC*) and the profession-specific Acts. The structures contained in the *HPPC* require, among other things, seven statutory committees:

- Registration Committee;
- Quality Assurance Committee;
- Fitness to Practise Committee;
- Complaints Committee;
- Discipline Committee;
- Patient Relations Committee, and
- Executive Committee.

The *HPPC* within the *RHPA* refers to these committees throughout the Code, giving jurisdiction and procedural instructions as needed. The following chart highlights the legislated functions of these committees.

CURRENT STATUTORY COLLEGE COMMITTEE STRUCTURE	
COMMITTEES	**MAIN FUNCTIONS**
Executive Committee	• Powers of council between council meetings, except to make, amend or revoke regulations or by-laws • Request an investigation related to quality assurance • Approve a registrar's request for an appointment of an investigator to conduct an investigation related to quality assurance, a mandatory or other report related to suspected professional misconduct or incompetence • Appoint a board of inquiry to inquire into whether a member is incapacitated • Refer an incapacity matter to the Fitness to Practise Committee and refer an allegation of professional misconduct to the Discipline Committee • Make an interim suspension or practice limitation order
Complaints Committee	• Investigate complaints • Consider the investigation findings related to a complaint • Decide on the disposition of a complaint (i.e. take action it considers appropriate such as dismissal, referral to discipline or issuance of a caution)
Discipline Committee	• Hold hearings of allegations of professional misconduct or incompetence referred to it • On finding professional misconduct or incompetence, make orders such as for a reprimand, revocation of a certificate of registration, suspension, imposition of terms, conditions and limitations on practice, and payment of a fine
Fitness to Practise Committee	• Hold hearings of suspected incapacity as referred to it • On finding incapacity, make orders for revocation of a certificate of registration, suspension, and imposition of terms, conditions and limitations on practice
Registration Committee	• Consider applications for registration that the Registrar refers to it • For applications it considers, direct the Registrar to issue or refuse a certificate of registration, impose conditions to be met for registration, and impose terms, conditions or limitations on a certificate of registration • Approve the application of terms, conditions or limitations on a certificate of registration if the Registrar is of the opinion this is needed
Quality Assurance Committee	• Appoint assessors for the QA program • Based on a QA assessment, make referrals as appropriate to Executive Committee for professional misconduct, incompetence or incapacity
Patient Relations Committee	• Advise the council with respect to the patient relations program • Administer the program for funding for therapy and counselling for persons who, while patients, were sexually abused by members

Consultation Input

The College of Nurses of Ontario and College of Physicians and Surgeons of Ontario proposed a revised committee structure. It would, in effect, create a single screening committee into which all information about a member would pass, regardless of the source of that information. The screening committee's main function would be to take the appropriate action with that information by either referring it to another committee, such as Discipline or Quality Assurance, or make a disposition without making a referral. Currently both Complaints and Executive committees have a screening function – Complaints Committee for formal complaints filed with a college and Executive Committee for mandatory and other reports on sexual abuse and for other reports on professional misconduct, incompetence, incapacity and all other issues of professional conduct that are brought to the attention of the college.

The screening committee proposal was discussed during subsequent roundtable discussions with the colleges and meetings with college representatives. There appeared to be general interest in the idea of streamlining committee structure. In addition, there was a shared concern about the information restrictions imposed by the current *RHPA* committee structure. It was felt that a revised structure featuring a screening committee could be one appropriate way to address the restriction.

Harry Cummings and Associates, which conducted the evaluation of college patient relations programs, found that the legislative requirement for a Patient Relations Committee was in many instances unnecessary or a barrier to comprehensive and integrated approaches to patient relations programming.

HPRAC Analysis

HPRAC carefully considered the proposal for a screening committee and the comments and reaction to that proposal and had further discussions with a number of stakeholders. It concluded that there is merit in reviewing the current committee structures based upon a functional assessment of what is required to achieve the desired outcomes of effectiveness, efficiency, flexibility, and fairness.

HPRAC considered the option of not specifying committee structures in legislation and allowing colleges full discretion to determine their own committees based on functions that would be specified in legislation. In HPRAC's view, not having statutory committees would necessitate instituting additional and more stringent mechanisms to ensure accountability of colleges in fulfilling the functions as intended. Further, HPRAC concluded that a common committee structure for all colleges would facilitate informing the public and health professionals about how matters of reports, complaints and other issues flow through the various proceedings. A common committee structure set out in the *RHPA* would also guarantee the appropriate separation of review and adjudicative functions and information handling that is necessary to satisfy the legal principle of unbiased decision-making.

HPRAC is of the view that the merits of the current prescribed system should be maintained and that the shortcomings of the current structures can be minimized without eliminating prescription of structures altogether. Consequently, HPRAC suggests maintaining a common structure and process prescribed in legislation for ease in accountability and comprehensibility for the public and college members. Keeping the functions separate and clearly defined by demarcation of specified committees and their mandates also ensures that the legal principle of non-biased decision-making is honoured. The one exception to this is the Patient Relations Committee as discussed further in this section.

Current structures for dealing with member-specific matters do not allow for efficient or flexible use of college resources or information flow. Indeed, it is arguable that the *RHPA* structures are too complex, time-consuming and convoluted to properly deal with the types of information colleges receive and/or collect about their members. At a number of colleges, for example, the Executive Committee currently spends a great deal of time simply reviewing case files to make decisions on possible referrals to other committees. At the same time, information is often "fire-walled" between the Executive and Complaints committees, leading to serious information restrictions that have the potential to compromise a college's ability to protect the public and hinder the transparency of the college's governing mandate.

HPRAC maintains that a complaints/screening committee, which would have access to all information regardless of its source, would better serve to protect the public. In addition, the freeing up of an Executive Committee's time and resources would allow for greater administrative efficiencies. Moreover, the process surrounding interim suspension or practice limitation orders is currently too restrictive to provide a timely response in situations where patients may be facing harm or injury because of a member's conduct or incapacity. The sharing of this power with a complaints/screening committee possessed of proper information would result in greater effectiveness, flexibility and administrative efficiency.

For this merging to be achieved, a new complaints/screening committee should be developed that would exercise the jurisdiction of the current Complaints Committee and also be responsible for case-specific allegations about professional misconduct, incompetency and incapacity now handled by the Executive Committee. The powers of the new committee would be those of the current Complaints Committee together with additional express powers of referral to the Quality Assurance Committee and the ability to issue interim orders of suspension or imposition. Executive Committee would retain its leadership role within the college and have the powers of council with respect to matters that require immediate attention between council meetings.

As reflected in Chapter 6 on Complaints and Discipline pages 69 and 70, HPRAC supports retaining the current provision that gives Executive Committee the power to order an interim suspension or practice limitation order. Retaining Executive Committee authority for interim orders as well as granting this authority to the complaints/screening committee would give colleges some flexibility in moving quickly to determine whether such an order or suspension is needed to protect the public.

In addition to merging Complaints and Executive Committee functions with respect to issues of member misconduct, incompetency and incapacity, HPRAC recommends achieving further

efficiencies by merging the adjudicative functions of the Discipline Committee and the Fitness to Practise Committee into a single adjudicative committee. This merged body could be called the Professional Conduct Committee. Currently, the Registrar, Executive Committee, Board of Inquiry and Fitness to Practise Committee are involved with questions of incapacity, which are dealt with in *RHPA* s.s. 57 to 69. HPRAC maintains that matters of incapacity should be referred to the merged adjudicative committee and that this committee should have jurisdiction to order appropriate investigations, consider all relevant materials, and decide what actions are appropriate in keeping with the procedures and authorities currently specified in the *HPPC* for incapacity hearings.

As noted above, an evaluation indicated that in many instances colleges' patient relations activities are integrated with other college activities and are not necessarily limited to the work of the Patient Relations Committee. Patient relations is a multi-faceted program that for some colleges is best designed and carried out through the programming of other committees and the college in general; e.g. through the activities of the Quality Assurance Committee, Complaints Committee, development of standards, and college Professional Practice Advisor. The evaluation consultants found that many colleges' Patient Relations Committees had a narrow focus. In large part, their focus was only on meeting the requirements specified in the Act for the Patient Relations Committee. Some committees expressed a view that they did not have much of a role at all given that the technical requirements of the legislation had been met and other committees were already engaged in activities that could be construed as patient relations.

Given the breadth of patient relations activities that must either influence or directly involve all college functions, it is questionable whether a dedicated committee is needed to carry out the statutory requirements. As an alternative, the various responsibilities that are currently assigned to the Patient Relations Committee may be best handled by different college committees. What is of utmost importance, however, is for all college activities to be planned, coordinated and evaluated to achieve the broad patient relations objectives. This coordination may be a unique role for a Patient Relations Committee, but HPRAC is of the view that colleges need flexibility to assign such functions. For this reason, HPRAC supports maintaining the statutory requirements for patient relations functions but giving colleges the flexibility to assign these within the college organization.

Such flexibility would allow the overall design, coordination and monitoring of patient relations approaches to be retained by the college council itself or assigned to an appropriate committee, such as Quality Assurance Committee. Colleges may also choose to create a new Patient Relations Committee.

HPRAC Recommendation(s)

12. **That the *Health Professions Procedural Code (HPPC)* be amended to merge the Complaints Committee functions and Executive Committee screening functions into a single complaints/screening committee with sufficient powers to make definitive dispositions arising from any type of complaint/report received about a member.**
13. **That the *HPPC* be amended to expand the new complaints/screening committee's powers of disposal to expressly include the authority to refer complaints, reports or**

other information to the Quality Assurance Committee for assessment of competencies and/or development of remediation programs, and the power to issue an interim suspension or practice limitation order.

14. **That the *HPPC* be amended to merge the functions of the Discipline Committee and the Fitness to Practise Committee to form a single adjudicative committee.**
15. **That the *HPPC* be amended to give jurisdiction over the investigation and referral disposition of incapacity matters to the complaints/screening committee.**
16. **That the *HPPC* be amended to give jurisdiction over the ultimate disposition of incapacity matters to the adjudicative committee instead of the Fitness to Practise Committee.**
17. **That the *HPPC* be amended to remove the requirement for a Patient Relations Committee but maintain the explicit requirements for the patient relations programs.**

The chart below highlights the proposed statutory committee structure and legislated functions.

RECOMMENDED STATUTORY COLLEGE COMMITTEE STRUCTURE	
COMMITTEES	**IMPACT ON MAIN FUNCTIONS**
Executive Committee	• Maintain powers of council between council meetings • Transfer the following functions to the Complaints/Screening Committee: 1. Appoint a board of inquiry 2. Refer incapacity matters for adjudication 3. Request investigations for mandatory and other reports to make including request • Retain authority to make referrals to discipline • Retain authority to make an interim suspension or practice limitation order • If not done by the Complaints/Screening Committee, monitor the inquiries and investigation of complaints and reports
Complaints/Screening Committee	• Monitor the inquiries and investigation of complaints and reports as initiated by the Registrar and keep the complainant and respondent informed of the progress of complaints • Expand consideration of complaints to include consideration of mandatory and all other reports of possible professional misconduct, incompetence and incapacity • Decide on the disposition of complaints, mandatory and other reports and take appropriate action including referring to the Quality Assurance Committee or the Professional Conduct Committee • Make interim suspension and practice limitation orders
Professional Conduct Committee	• Hold hearings of allegations of professional misconduct, incompetence and incapacity • On finding of professional misconduct, incompetence or incapacity, make orders as appropriate

Registration Committee	• No change
Quality Assurance Committee	• No change
Patient Relations Program functions – college council to assign the functions and the coordination of patient relations activities.	

4. Public Appointees on College Councils

The *RHPA* requires public appointments to be made by the Lieutenant Governor in Council (the Cabinet) and the Minister of Health and Long-Term Care is responsible for the remuneration of public appointees.[24] The Act has no specific provisions for the orientation or training of public members.

Feedback from submissions received in response to the consultation document was concentrated primarily in the areas of the selection/appointment process, orientation and training and remuneration of public members.

Selection/Appointment Process

Consultation Input

A large and diverse group of respondents – including the Federation of Health Regulatory Colleges of Ontario, professional associations, consumer advocacy groups, health organizations and half of the regulatory colleges – identified the need for public appointees to better represent the geographic, cultural and demographic diversity of Ontario and to include representation in terms of gender, language and aboriginal persons.

Some professional associations, consumer advocacy groups, health organizations and individual health providers raised concerns about the perceived lack of openness and transparency in the government's selection process. Some recommended that the process for selecting public members be more open and that vacant positions be advertised to the public. A number of respondents stated that public members should not be political appointees but should be chosen for their interest in health care. Suggestions included members of health care advocacy groups or health advocates, or members chosen on the basis of their volunteer work, individual merit or interest in a health profession.

Many of the colleges and some professional associations commented on the lack of timeliness of public appointments as creating a barrier to effective operation of college councils and committees. Recommendations included revising legislative provisions that set terms of quorum on college councils for greater flexibility and appointing public members in advance of end dates for council appointments.

[24] Section 8 of the *Health Professions Procedural Code (HPPC)*.

HPRAC Analysis

HPRAC is of the view that public members have an essential role to play within the regulatory system. They are both a voice and advocate for the public interest on college councils.

The current approval process leading to order-in-council appointments of public members involves many steps and requires several levels of government approval. Given the significant number of competing government priorities, this multi-step system is not always conducive to timely public appointments. HPRAC maintains that appointments of public members to college councils should be done in a timely manner to ensure the efficient functioning of the regulatory system. All colleges must always have sufficient numbers of members on their councils to fulfil their duties and responsibilities under the *RHPA*.

Consequently, HPRAC suggests that, in the interest of efficiency and timeliness, the Minister may wish to explore mechanisms other than orders-in-council, such as ministerial appointments, to appoint members to college councils. Furthermore, to expedite appointments, HPRAC is of the view that the Minister should develop service standards for the appointment process (see Recommendation 58, page 116, Chapter 10 on Roles and Responsibilities).

HPRAC is of the view that appointments should be criteria-based to reflect both the needs identified by colleges and the characteristics of effective governing bodies as promoted by the Canadian Comprehensive Auditing Foundation. These characteristics are as follows:

- being composed of people with the necessary knowledge, ability and commitment to fulfil their responsibilities;
- understanding their purposes and whose interests they represent;
- understanding the objectives and strategies of the organizations they govern;
- knowing and obtaining the information they require to exercise their responsibilities;
- once informed, being prepared to act to ensure that the organization's objectives are met and that performance is satisfactory;
- fulfilling their accountability obligations to those whose interests they represent by reporting on their organization's performance.[25]

Orientation/Training

Consultation Input

A large number of respondents – mainly the regulatory colleges, the Federation of Health Regulatory Colleges and individual health providers – stated that public members seem to lack appropriate orientation/training to quickly and fully familiarize them with:

- the *RHPA* and profession-specific Acts;
- the role of the health profession regulated colleges;
- the practice issues of the profession; and

[25] *Governance Information: Strategies for Success.*

- their own role as public members.

Some respondents stated there was a tendency for public members to defer to professional members in decision-making processes and not challenge the professionals. These respondents suggested that adequate orientation/training would better prepare public members for their role on college councils.

The majority of respondents who commented suggested that the Ministry of Health and Long-Term Care should be responsible for the orientation/training of public appointees. A smaller number suggested that the regulatory colleges and the ministry should share this responsibility, while one respondent suggested that this task should be a responsibility of the colleges.

HPRAC Analysis

HPRAC notes the emphasis that the Canadian Comprehensive Auditing Foundation places on knowledge, understanding, commitment and access to information in its list of important characteristics for effective governing bodies. These characteristics have guided HPRAC's consideration of how to prepare public appointees and increase their capacity to represent the public interest on college councils.

HPRAC reviewed the orientation/training programs and printed resource materials provided to committee/board members of selected government agencies/boards that have administrative and/or adjudicative responsibilities. These included the Travel Industry Council of Ontario, the Assessment and Review Board and the Consent and Capacity Board. Each of these organizations provides some level of initial orientation for members as well as access to, and payment for, ongoing annual seminars or training sessions. It is felt that this type of training helps public members keep abreast of issues relevant to their particular field and provides them with specific skills to carry out their role.

HPRAC understands that resources within the ministry are limited and priorities must be set for government expenditures. However, to carry out their role to represent the public interest, public members must first be knowledgeable about their role and responsibilities on college councils, and have access to information and other supports. HPRAC maintains that it is imperative for public members to be oriented within two, maximum three, months of their appointment and have the benefit of ongoing access to information and other supports. Increasing the capacity of public appointees to be effective members will contribute to the effectiveness of the regulatory system.

Orientation and training should be a joint responsibility of the ministry and colleges. HPRAC concludes that as a group colleges are best positioned to provide the leadership for developing effective public member orientation by virtue of their expertise in health professional regulation and profession-specific knowledge. Colleges, perhaps led by the Federation of Health Regulatory Colleges, should assume the responsibility to design and provide the content for public member orientation and ongoing training programs. The ministry, through course fees and per diems, should continue to provide adequate funding for public member education – both for orientation

and on a continuing basis. This ministry responsibility acknowledges that public members appointed to represent the public interest are a provincial resource that must be supported.

Orientation and training are the keys to making the contributions of public members effective, informed and significant. Strong public members are essential to having effective and accountable governance of the regulated health professions.

HPRAC notes that the Citizens' Advocacy Centre (CAC) was established in the U.S. in 1989. A not-for-profit organization, the CAC was created to serve the public interest by providing research, training, technical support and networking opportunities for public members of health care regulatory and governing boards. The goal is to equip public appointees with the ability to serve public policy goals more effectively and efficiently.

The CAC disseminates information and provides forums for the examination of public policy affecting health care delivery and regulation. It also distributes a quarterly newsletter, produces research reports on topics of current and practical concern to regulatory and governing bodies, holds an annual conference, and conducts training seminars for individuals, states and regulatory bodies.

HPRAC suggests that Ontario take the lead in developing a Canadian equivalent to the Citizens' Advocacy Centre. This organization could provide support to public members on a national level by:

- disseminating information on the role and responsibilities of public members;
- identifying best practices;
- providing a forum for public members to share experiences;
- gathering information (literature, trends, opinions) on issues that affect the public; and
- reporting on professional regulation in other jurisdictions.

HPRAC is of the view that a Canada-wide organization similar to the CAC would be beneficial to colleges, the public, and the regulatory system as a whole. It would increase the public's access to information. It would also reduce the isolation of public members, encourage communication among them and provide opportunities for technical support and networking. As a result, the public's interest would be better served.

HPRAC acknowledges that information and training resources currently exist and could be utilized to a greater degree to support public members in their key role. Better dissemination may be an issue. Public members may also find value in meeting with public appointees from other college councils to share information and discuss mutual concerns. HPRAC suggests that the public members themselves are in the best position to identify their information/training and support needs and should be given the opportunity to do so.

HPRAC Recommendation(s)

18. That information be provided to public appointees before their appointment informing them of their role and responsibilities on college councils.

19. **That the selection of public appointees to college councils be criteria-based and that these criteria include necessary knowledge, abilities and commitment to fulfil the role as a public representative as well as specific knowledge and skills needed by individual colleges.**
20. **That the Ministry of Health and Long-Term Care clearly articulate to colleges that it is the colleges' responsibility to orient and train public members and encourage colleges to ensure public members are oriented to their role.**
21. **That the Minister establish a public member resource committee/task force made up of public appointees and representatives from the Federation of Health Regulatory Colleges and the ministry to:**
    - **identify and develop programs and other resources to orient and support public members;**
    - **develop reliable mechanisms for public members to access and share information;**
    - **develop mechanisms for public members to meet periodically to discuss mutual concerns; and**
    - **explore the development of a national body to coordinate the dissemination of resources and link the public with public interest representatives on governing bodies for professions.**

Remuneration

Consultation Input

A small group of respondents, including colleges, consumer advocacy groups, a professional association, a health organization and a district health council, suggested that financial remuneration for public members should be equal to the remuneration of elected members on college councils. The Arnt/Belza submission suggested that reforming the remuneration for public appointees may have a positive effect on the quality of public representation.

HPRAC Analysis

HPRAC understands that the per diem rate of public appointees is significantly lower than that of many professional members of college councils, and that the per diem rate has not increased since 1994.

To gain insight into the practices within other areas, HPRAC reviewed the remuneration rates for committee/board members of selected government boards/agencies with administrative or adjudicative responsibilities. These included the Travel Industry Council of Ontario, the Assessment and Review Board and the Consent and Capacity Board.

Only on the Consent and Capacity Board are professional members paid more than public appointees. HPRAC notes that this board is required by law to have one lawyer and one psychiatrist as members. Adjudicative board members have a higher per diem than administrative board members. Although many public members on college councils have an equivalent review or adjudicative role, their remuneration rate does not reflect this function.

HPRAC is of the view that public members on college councils should have equal remuneration with public appointees on other boards and councils who have a similar function.

Chapter 6 Complaints and Discipline

This chapter deals with complaints and discipline procedures related to professional misconduct of a general nature, complaints of a sexual nature, and the requirements under the *Regulated Health Professions Act* for colleges in dealing with these two types of complaints. This chapter is organized into three main sections under the following headings:

Section 1: Complaints of Professional Misconduct of a General Nature

1. Panel Composition
2. Nature of "Complaint"
3. Investigation Reports
4. Timely Disposal of a Complaint
5. Standard for Referral to Discipline
6. Powers of a Complaints Panel
7. Interim Suspension and Practice Limitation Orders
8. Appeal to the Health Professions Appeal and Review Board

Section 2: Discipline of Professional Misconduct of a General Nature

9. Power/Composition of Discipline Panels
10. Party Status for Complainants
11. Evidence
12. Hearing Process
13. Orders
14. Appeals

Section 3: Complaints and Discipline for Professional Misconduct of a Sexual Nature

The *RHPA* stipulates that HPRAC is to report to the Minister of Health and Long-Term Care on the effectiveness of regulatory colleges' complaints and discipline procedures for professional misconduct of a sexual nature. Therefore, HPRAC undertook a separate study of colleges' handling of such cases and submitted its recommendations to the Minster under a separate report dated December 2000. The findings of that report and the HPRAC recommendations to the Minister are discussed in section 3 of this chapter.

In this chapter, HPRAC will also consider to what extent its December 2000 recommendations on proceedings for misconduct of a sexual nature should apply to all complaints or discipline proceedings, regardless of the nature of the complaint.

Many participants in the public consultation on the Review Referral, in program evaluation and in the Special Task Force on Sexual Abuse proceedings expressed their anger and despondency about their experiences with colleges, their lack of trust and confidence in the complaints and discipline processes and their perceptions of college conflict of interest in the handling of complaints of both a sexual and general nature.

Section 1: Complaints of Professional Misconduct of a General Nature

In this section, HPRAC evaluates the complaints and discipline process of the *RHPA* in cases of professional misconduct of a non-sexual nature. The principles most relevant in this consideration are protection from harm, accountability, efficiency and fairness.

The procedures underlying the *RHPA* complaints and discipline processes are perhaps the most legalistically informed of the Act. While these processes are part of administrative law, they are not without serious legal and professional consequences for the member. Accordingly, consequences will often inform due process requirements associated with the complaints and discipline process.

For most members of the public, the complaints process is the avenue through which they come into contact with one of the regulatory colleges. It is the process through which a person can bring to a college's attention the conduct or actions of a member that are considered to fall below the professional standards expected of the member.

1. Panel Composition

Currently, the *Health Professions Procedural Code* (*HPPC*), Schedule 2 of the *RHPA*, provides that panels of a college's Complaints Committee be composed of at least three council members, at least one of whom must be a "public appointed member."

Consultation Input

Two chief issues arose about the composition of the Complaints Committee: public member participation and qualifications of members who sit on the panels.

It was generally thought that public members played an important role in avoiding any appearance of bias on the part of a complaints panel. Public members were thought to bring a "consumer" or "public interest" outlook, which was considered an important means of balancing "professional opinion." There also appeared to be consensus that it was important for at least one panel member to be a public appointed member.

A small number of submissions supported the idea that the majority on a panel must be public appointed members so as to avoid the public member being isolated or "over-ruled" by the profession members. Other submissions, however, acknowledged that self-regulation would be undermined if the panel composition were changed to require a majority of public appointed members. Generally speaking, all submissions implicitly or explicitly acknowledged the vital role that public members played on the panels of Complaints Committees.

With respect to qualifications, some submissions indicated that the health professionals who serve on the panels should have a high level of knowledge of clinical issues in the profession. It was also submitted that the professionals who sit on panels must fully understand the requirements of the profession and be able to interpret activities from within the perspective of

its scope of practice. Some submissions also recognized the need to ensure that both public and professional members received adequate training and support to serve on the panels.

HPRAC Analysis

HPRAC concluded that the current understanding of self-regulation should continue to be applicable to the regulated health professions in Ontario (see section on College Council Structure in Chapter 5 on College Governance page 43). Self-regulation is not a perfect model, but in HPRAC's view it does have the potential to work in favour of the public interest while not sacrificing fairness for health professionals. Thus HPRAC concluded that, in general, the current Complaints Committee structure and recommended Complaints/Screening Committee represent an appropriate balance between the needs for efficiency and accountability within professional self-regulation.

HPRAC is also of the view that, given the important role they play, it is entirely appropriate that public members be proportionally represented on panels of the Complaints Committee. Thus in cases where a panel is composed of five members, at least two should be public members; where a panel has seven members, three must be public appointed members, etc.

It is important to recognize the importance of the role played by public members on all college panels, and in particular their role on Complaints Committee panels. Given the gatekeeping function of such panels, the presence of well-trained public appointees should instill public confidence in the complaints system. The presence of public members helps counteract the impression of bias that some consumers have with a panel composed entirely of profession members. Public members also help ensure transparency and accountability in the complaints process.

HPRAC Recommendation(s)

22. That the composition of panels of the Complaints Committee as established by s. 25(2) of the *HPPC* continue to require that at least one public appointed member of the college council be on the panel, and that there be a simple majority minus one of public members if a panel sits in large numbers; for example, two public members for a five-member panel, three public members for a seven-member panel.

2. Nature of "Complaint"

The *HPPC* defines a "complaint" in terms of its form, not its substance. Thus s. 25(4) requires that the complaint must be "in writing or is recorded on a tape, film, disk or other medium." There is no statutory definition as to what constitutes a complaint per se.

Consultation Input

Throughout the submissions on the nature of a complaint, a number of issues arose in the areas of content and definition of complaint, third party complaints and the protection of vulnerable complainants. Some members of the public were concerned that the *RHPA* does not clearly define what constitutes a complaint.

In regard to content and definition, a number of submissions noted that the *RHPA* does not define what constitutes a complaint. This lack of definition has not proven detrimental, as several submissions observed that the lack of definition gave colleges the necessary flexibility to handle information coming in. The same conduct or action may be perceived differently by different people and flexibility ensures that differences among consumers are respected.

It was also noted that defining a complaint might deter people from coming forward with information that, while clearly relevant to a member's conduct or actions, would be lost because the person did not want to make a "formal complaint." Moreover, a legal definition of a "complaint" might prove to be too restrictive or unnecessarily limit the rights of patients to make a complaint about conduct they object to.

Some submissions commented on the need and/or desirability of defining "frivolous or vexatious" either through statute or college guidelines to ensure fairness and discourage arbitrary dismissal of complaints on those grounds. However, other submissions stated that there should be no definition of "frivolous or vexatious" to allow for flexibility of the standard on a case-by-case basis. It would be up to the panel reviewing the complaint to make the decision based upon common sense and its experience. [26]

On third party complaints, a number of submissions indicated that it was very important to allow third parties to bring forward complaints on behalf of others, especially those who are vulnerable, such as minors, the aged, those suffering from mental or physical infirmities or where the patient has died. It was noted that "complainant" is not defined in the legislation and thus it is currently flexible enough to accommodate third party complaints.

On the other hand, a number of submissions indicated that third party complaints should be allowed only from a patient's legal representative or guardian. Several submissions noted that there is a potential tension between the patient, who may not want to bring a complaint, and the third party complainant who feels compelled to come forward in the interests of both the patient and the broader community. In this regard, it was noted that it may be very difficult for a college to investigate or even to proceed to discipline where the patients themselves do not want to become involved. It was also submitted that a third party complaint should not proceed in the absence of a willing patient connected with the complaint.

Related to the issue of third party complaints is that of protection of vulnerable complainants. A number of submissions from members of the public and advocacy groups made the point that any number of people feel disadvantaged when attempting to access college complaints

[26] Decisions to dismiss a complaint that is deemed to be frivolous or vexatious are reviewable by HPARB at the request of the complainant, respondent or college.

processes and that complaints brought by third parties on behalf of such vulnerable people should be handled with great care. "Vulnerability" was expressed in the submissions to include a wide range of people and situations, from personal attributes to geographic locations.

In addition, submissions addressed vulnerability in the practical terms of barriers to making a complaint, especially in institutional settings. These barriers include lack of access (e.g., to a telephone), privacy (not being able to receive and read mail from a college without others knowing) and basic information about knowing one had the right to complain. It was submitted that third party complaints were one mechanism through which vulnerable people could achieve some success in exercising their right to make a complaint.

HPRAC Analysis

HPRAC understands that to effectively access the complaints process, a certain degree of flexibility and discretion is required by both the people filing complaints and the colleges that bear the responsibility of acting upon complaints or other types of information received.

HPRAC does not find that the principles of protection from harm or accountability would be further advanced by creating rigid statutory definitions of either "complaints" or "complainants." Indeed, in the view of HPRAC, accountability requires that every person have the right to make a complaint against a regulated health professional for conduct or actions that may appear to fall below the professional standards expected of a member of a college. A statutory definition of "complaint" could lead to a narrow interpretation of "complainant" and thereby inhibit people from voicing legitimate concerns and/or grievances.

Similarly, if "complainant" were restricted to only a patient/client of a health care practitioner, undue constraints would be placed upon those who should be able to bring to a college's attention conduct or actions requiring at least investigation if not further action.

Moreover, the practical reality is that each instance of interaction between a health care practitioner and a patient/client is different, given clinical and personal characteristics. The reporting of potential substandard care should not be arbitrarily hindered because of legalities surrounding a definition of what constitutes a "complaint."

Similarly, the ability of third parties to make complaints should not be arbitrarily determined or limited by simply relying upon a pre-existing clinical relationship with the patient/client. Professions are regulated in the public interest and if a member of the public wishes to bring a complaint forward, he or she should be able to do so in furtherance of the public interest as well as in the interests of the patient/client.

There are clearly instances of patients/clients who, for whatever reason, do not wish to bring a complaint forward, or cannot do so. At the same time, however, there is the broader public interest at stake that seeks to protect from harm all members of the community. Third party complaints are one method by which this tension between the public and private can be reconciled, at least in some cases.

Self-regulation in the public interest works only to the extent that the public takes advantage of its rights to access the complaints process, either on its own behalf or on behalf of another. HPRAC contends that there is at present a workable balance between public, professional and private interests with respect to the nature of a complaint.

3. Investigation Reports

Once a complaint has been received by a college, s. 26(1) of the *HPPC* requires that the member who is the subject of the complaint (respondent) be given an opportunity to respond in writing to the complaint within 30 days after receiving notice of the complaint. At present, no provision allows either complainants or respondents to comment on the recording of the information they have supplied to a college during the course of a complaint investigation.

Consultation Input

A number of submissions raised concerns about the manner in which investigations were carried out by colleges. They questioned whether the complainant's or respondent's information was being fully transmitted to the panel of the Complaints Committee. A fear was expressed that complainants were not being treated fairly. Some members of the public questioned whether complaints were being thoroughly investigated.

HPRAC Analysis

In its report to the Minister on the complaints and discipline procedures for professional misconduct of a sexual nature, HPRAC noted the importance of ensuring that the complainants have confidence in the process and in the accuracy of the record of their complaints together with any statements given to college investigators. HPRAC concluded that the best way to ensure that confidence was to allow the complainant and respondent the opportunity to provide a written submission on the recording of their respective statements to college investigators, before the investigator's report was given to the panel of the Complaints Committee. HPRAC also concluded that the panel members should include those submissions as part of their deliberations.

HPRAC is of the view that the same rights of response to the investigator's report should be afforded complainants and respondents in complaints of professional misconduct of a non-sexual nature. The investigation stage of the complaints process is primarily concerned with information gathering and HPRAC has concluded that offering the complainant and respondent the opportunity to comment upon the information of which they are the source will provide an opportunity to correct investigation errors. It will also give the complainant and respondent a certain degree of confidence in knowing that the record of their statement is correct. In addition, the right to comment on the investigator's recording of their statements adds a level of accountability because the accuracy of the report will be open to scrutiny.

Finally, HPRAC maintains that a process that encourages complainants to come forward is one in which complainants know they have been given an adequate opportunity to state their complaint. They know that disposition of the complaint rests with a panel that has clear information about their complaint. HPRAC notes that providing these additional pieces of

information to a Complaints Committee panel will accomplish two things. It will give the panel a fuller and more accurate picture of the complaint and it will help ensure confidence in the accuracy of the information before the panel.

In addition, HPRAC is of the view that allowing the complainant and respondent to respond to certain information at an earlier stage of the complaints process may save additional time by reducing the need for appeals to the Health Professions Review and Appeal Board.

HPRAC appreciates that its recommendation on the right to make submissions on investigator's reports means that additional time will be required to process complaints. Therefore, it recommends that 30 days be added to the current 120-day requirement for disposing of a complaint.

Ultimately, however, the exact time frame will be difficult to establish without information on best practices. HPRAC is confident of the colleges' commitment to deal with complaints in an expeditious yet fair manner. Ongoing monitoring and evaluation as indicated in Chapter 10 are critical to ensuring that matters are dealt with within optimal and fair time lines.

HPRAC Recommendation(s)

23. That s. 26 of the *HPPC* be amended to allow both complainant and respondent the opportunity to comment in writing, within 30 days of the receipt of the statement, on their respective statements as recorded by the investigator and that those comments be part of the materials presented to the panel of the Complaints Committee before it makes its decisions.

24. That s. 28 of the *HPPC* be amended to require that a panel shall dispose of a complaint within 150 days after the filing of the complaint.

4. Timely Disposal of a Complaint

Section 28 of the *HPPC* provides that a panel of the Complaints Committee shall dispose of a complaint within 120 days after the filing of the complaint.

Consultation Input

Through written submissions and subsequent roundtable discussions held with colleges and the public, HPRAC learned that for complainants, respondents and colleges, the lack of timely response to complaints is a major area of dissatisfaction. Members of the public in particular expressed dismay at the time it takes for a complaint to be resolved.

A number of submissions pointed to problems with delays and the fact that some colleges were telling complainants to expect a process lasting up to two years or more. A number of submissions felt that 120 days was enough time to come to a conclusion about the merits of the complaint. Delays caused individuals to experience undue stress and lack of confidence in the college to effectively regulate their members.

From the perspective of members, delay in resolving a complaint was not only a cause of undue stress but also deprived the member of fairness.

From the colleges' perspective, a number of submissions suggested that the time frame of 120 days was simply too short for the investigation required, notice requirements for members, and getting additional information from a complainant. While some colleges were able to meet the 120-day time frame, most others were not.

While there was overall concern about the delay, a number of submissions indicated that time lines were necessary to ensure that unnecessary delays did not occur and to give some sense of order and expectation to the process.

HPRAC Analysis

In its report on the complaints and discipline process for professional misconduct of a sexual nature, HPRAC recognized that the 120-day time frame for the disposal of a complaint was difficult for most colleges to meet. Similarly, the submissions received in response to *Weighing the Balance* clearly indicate that, for the most part, consumers do not find colleges are meeting the 120-day time frame for disposing of a complaint.

Obviously, there must be a balance achieved between the timely disposal of a complaint and the time required to have the member respond and the college conduct a proper investigation of the complaint. HPRAC contends that its recommendation on time frames for disposing of sexual abuse complaints is also germane for non-sexual complaints. The reasons are the same: the importance of communicating to complainants the reasons for the delay together with a revised time frame for disposing of the complaint.

As discussed in Chapter 10, monitoring and evaluation of the complaints proceedings timelines are important to promote optimal efficiency and fairness.

HPRAC Recommendation(s)

25. That the *HPPC* be amended to require that when statutory time frames cannot be met, colleges give notice to complainants and respondents advising them of the reasons for the delay(s) and revised time frame(s) for the disposition of the complaint.

5. Standard for Referral to Discipline

Currently, the *HPPC* provides that the panel makes its decision on the disposition of a complaint after "investigating a complaint…considering the submissions of the member and considering or making reasonable efforts to consider all records and documents it considers relevant to the complaint…."[27]

[27] Subsection 26(2) of the *HPPC*.

The panel conducts an "investigation" and then a "consideration" of the complaint and investigation material. It does not hold, nor is it required to hold, a "hearing." Instead, the panel's consideration of the complaint is entirely paper-driven. The *HPPC* is silent as to the standard that must be met before the panel makes a referral to the Discipline Committee.

Consultation Input

HPRAC received a number of comments about confusion on the part of complainants as to why their complaints were dismissed. There seemed to be a general lack of awareness about the legal standards that govern whether a complaint is referred to the Discipline Committee. Some members of the public and advocacy groups commented that too few complaints are being referred to the Discipline Committee.

HPRAC Analysis

This general confusion about legal standards became apparent to HPRAC during its review of the complaints and discipline process for professional misconduct of a sexual nature. It recommended that the referral standard for complaints to go to discipline be clearly articulated in the legislation.

HPRAC suggests that the reasoning for that recommendation is also applicable to complaints of a non-sexual nature. Specifically, there should be a clearly articulated standard for referral to discipline that is readily ascertainable and based on the seriousness of the conduct in question and on the sufficiency and quality of the admissible evidence. Neither the Executive nor the Complaints Committee is involved with adjudicating the credibility of the information before it. Rather, its consideration is to establish whether there is sufficiency of admissible evidence of a serious nature to refer the matter to discipline. If both these criteria are met, then the matter ought to be referred to discipline.

HPRAC Recommendation(s)

26. That s.s. 26 and 36 be amended to require a committee considering a complaint or other report to refer the allegation of professional misconduct to the Discipline Committee where the committee is satisfied that: (1) the allegation is considered serious by the college and/or the panel considering the matter; and (2) the information provided in the complaint or other report, and through subsequent investigation, provides admissible evidence that, if believed by the discipline panel, could result in a finding of professional misconduct.

6. Powers of a Complaints Panel

Under the *HPPC*, the powers of a panel of the Complaints Committee are:

- investigate complaint;
- refer complaint to Discipline Committee;
- refer member to the Executive Committee for incapacity proceedings;

- issue a caution to the member;
- take action it considers appropriate that is not inconsistent with the *RHPA*, the *HPPC*, the regulations or by-laws;
- refer the matter to the Quality Assurance Committee if the allegation is about sexual abuse as defined in s. 1(3)(c) of the *HPPC*; and
- take no action on a complaint it finds is frivolous, vexatious, made in bad faith or is otherwise an abuse of process.[28]

Consultation Input

HPRAC received a variety of submissions on the question of the powers of the Complaints Committee and its panels. In doing so it raised a number of important issues about not only the panel's powers but also its responsibilities.

Perhaps the most common theme that emerged was the role of the Complaints Committee as a screening committee and whether it has sufficient powers to act as such. Consistent with this theme was the associated issue of better defining the role of the Complaints Committee as a body that "considers" rather then "investigates" the complaint. It was submitted that the committee should have the express power to order remediation by members of substandard practice as well as full authority to enter into undertaking agreements with members in order to monitor and/or enforce the remediation action.

Other submissions commented on the role of the Complaints Committee in alternative dispute resolution (ADR) programs and its commensurate role in remediation. It was noted that early resolutions of complaints through mediation offered the possibility of increasing both efficiency and complainant satisfaction in knowing the complaint had been dealt with in a timely manner. It was also submitted that frivolous and vexatious complaints ought to be "dismissed" earlier rather then later in the complaints process to achieve administrative efficiency and fairness to the respondent.

HPRAC Analysis

In its report on complaints and discipline procedures for professional misconduct of a sexual nature, HPRAC recommended that the *HPPC* be amended to state that the Registrar is to "investigate" a complaint and that the panel of the Complaints Committee must "consider" the results of the investigation and decide on the disposition of the complaint in accordance with the powers granted to the committee.

HPRAC maintains that this change in function should apply to all complaints regardless of their nature. The change is prompted by the reality of how most colleges operate in relation to the complaints process and by the recognition that the panels of the Complaints Committee are moving towards a more judicial-based model.

[28] Sections 25 and 26 of the *HPPC*.

At the same time, HPRAC acknowledges that it is important to ensure accountability for the investigations is maintained throughout the investigation process. Therefore, it has also recommended that the Complaints Committee be required to monitor the process of all complaints. Principles of self-governance require that the elected/appointed members of a college council and its committees be ultimately responsible for the activities of the college.

One of the most common themes advanced throughout this review has been the use of ADR as a means of resolving complaints. HPRAC has become aware that colleges use ADR differently and have different names for the process. In the report on complaints and discipline procedures for professional misconduct of a sexual nature, HPRAC recommended certain restrictions on the use of ADR, that ADR settlements be subject to committee approval, and that there be strict publication requirements for ADR settlements related to remediation.

However, HPRAC maintains that to provide for accountability and protection from harm, all ADR settlements involving remediation should be made part of the Register that is available to the public. In addition, HPRAC asserts that any ADR settlements reached prior to a referral to discipline must be subject to approval by a panel of the Complaints Committee.

To ensure that ADR is used only in appropriate cases and to provide for clear guidelines on the identification of those cases, HPRAC is of the view that the categories of cases appropriate for ADR at the complaints stage should be articulated in the *HPPC*. These categories should not involve behaviour deemed serious by the college. Rather they should be instances of minor conduct that have not resulted in harm and that are not indicative of more serious concerns about professional misconduct or a pattern of substandard practice.

Given the importance of quality assurance and its high profile within the *RHPA* regime, complaints may in many instances be settled through prompt referrals to the Quality Assurance Committee rather than through a referral to discipline. Indeed, discipline may not be appropriate for a great many complaints while quality assurance mechanisms are. Accordingly, referral to the Quality Assurance Committee should be specifically provided for as an option for a panel of the Complaints Committee.

HPRAC Recommendation(s)

27. **That s. 25 of the *HPPC* be amended to provide that the Registrar shall conduct all investigations of complaints and that a panel of the Complaints Committee shall consider all investigations so conducted.**
28. **That the *HPPC* be amended to require that the Complaints Committee or Executive Committee be responsible for monitoring the progress of all complaints and ensure that optimal time lines are met for the disposal of all complaints.**
29. **That s. 23 of the *HPPC* be amended to require that all ADR settlements be subject to approval by a panel of the Complaints Committee and that remediation undertakings that are part of a settlement be published on the Register available to the public.**
30. **That the *HPPC* be amended to specifically provide that ADR may be used only to deal with complaints of the following nature: poor communications; inaccurate or**

poor documentation and/or record keeping; rude behaviour not indicative of serious practice deficiencies; isolated standards of practice failures not resulting in serious harm; breach of confidentiality; conflicts of interests; and behaviours not indicative of a pattern of practice deficiencies.

31. **That s. 26 of the *HPPC* be amended to include an express provision allowing a panel of the Complaints Committee to refer the member to the Quality Assurance Committee for assessment of competencies and/or determination of appropriate remediation programs.**

7. Interim Suspension and Practice Limitation Orders

Section 37 of the *HPPC* provides the Executive Committee with a power to issue an interim suspension order for a member or order that a limitation(s) be placed on the member's practice where an allegation is referred to the Discipline Committee and where it is of the opinion that the conduct of the member exposes or is likely to expose his or her patients to harm or injury. The order for suspension or practice limitation may only be made where notice of intention and at least 14 days to make written submissions have been given to the member.

Consultation Input

A number of submissions addressed the problems associated with the limitation order and order for interim suspension of members. It was noted that the procedure was cumbersome because the Executive Committee needed to "form an intention" to make the order and give notice of the order. In addition, 14 days' notice to reply seemed not immediate enough. These two requirements prevent colleges from acting quickly to prevent harm. The authority to make the order rests solely with the Executive Committee and it was suggested that the college Registrars should also have this authority. Finally, concerns were raised about the test of "likely to expose patients to harm" as it was considered too high a threshold to meet.

HPRAC Analysis

HPRAC acknowledges that interim suspensions and practice limitation orders can be effective tools in protecting the public from harm in situations where a Discipline Committee has yet to render a final decision. However, the process by which such an order is made must also be expeditious and fair. HPRAC has concluded that the decision to make an interim suspension or limitation order should continue with members of college council and not with college staff such as the Registrar.

Accordingly, HPRAC is of the view that the Executive Committee should retain jurisdiction to issue interim suspension or practice limitation orders. In addition, given its recommendations on committee restructuring in Chapter 5 of this report, HPRAC also concludes it is appropriate that the Complaints/Screening committee have jurisdiction to issue a limitation or interim suspension order.

Effectiveness also requires that the order be able to be used immediately in situations where either the Executive or Complaints/Screening Committee is satisfied that the conduct of the

member will expose his/her patients to harm or injury. The current system is simply too cumbersome to be effective.

To safeguard against abuse of process and address certain procedural concerns, HPRAC maintains it is appropriate that the committee making the order do so on a "balance of probabilities" that harm or injury will occur if the order is not made. The clearer standard of "balance of probabilities" is preferable to the current rather equivocal "opinion that the conduct of the member exposes or is likely to expose" which suggests a higher standard associated with certainty. In addition, there ought to be full disclosure to the member of the information relied upon by the committee at the time the order is made.

To expedite orders, instead of allowing 14 days for the member to make a submission before the order is made, HPRAC supports a new approach whereby a review of the order would take place if the member requests a review within three days of receiving notice of the order. The order ought to lapse if the committee issuing it fails to review that order and any written submissions made by the member within three days of the request for a review. This will allow more immediate action by a college to protect patients as it provides for a total of six days for the member to request and the college to convene a review of an interim suspension or limitation order. There would be no requirement at this stage to hold a hearing.

HPRAC is also of the view that the order should lapse within 12 months of it being made if a discipline hearing is not concluded within that time on the matter that gave rise to the interim suspension or limitation order. This change will ensure fairness to the member by expediting the discipline hearing.

HPRAC concludes that the benefits of providing colleges with a quick, yet reviewable, power to order an interim suspension or practice limitation will enhance public protection in those rare circumstances where immediate action is required. HPRAC has also concluded that the new process for interim suspension and practice limitation orders should also apply to cases of incapacity.

HPRAC Recommendation(s)

32. That s. 37 and s. 62 of the *HPPC* be amended to allow either the Executive Committee or the Complaints/Screening Committee to issue an interim suspension or practice limitation order effective immediately if it is satisfied that, on the balance of probabilities, the conduct of the member would expose his or her patients to harm or injury.

33. That s. 37 and s. 63 require the committee to disclose to the member at the time the order is issued all relevant information and materials relied upon by the committee in making its decision, its reasons for issuing the order, and the member's right to request that the order be reviewed within three days.

34. That s. 37 and s. 63 of the *HPPC* be amended to provide the member with the right to request a review of the suspension or practice limitation order by the committee or panel making the order within three days of being given the order, and further

provide that, if the committee or panel fails to consider the review within the three days of the request, the order shall lapse.

35. **That s. 37(3) and s. 62(3) of the *HPPC* be amended to state that an order expires after 12 months or upon disposition by the Discipline Committee, whichever occurs first.**

8. Appeal to the Health Professions Appeal and Review Board

Under s. 29 of the *HPPC*, a complainant or a member may appeal a decision of the Complaints Committee unless that decision resulted in a referral of an allegation of professional misconduct or incompetence to the Discipline Committee or if the member is referred to the Executive Committee for incapacity proceedings. The complainant and the member are parties to the review, although HPARB may require that the college send a representative. In its review, HPARB is to consider either the adequacy of the investigation conducted or the reasonableness of the decision or both.

After conducting its review, HPARB may do one or more of the following: confirm all or part of the decision of the Complaints Committee panel; make recommendations HPARB considers appropriate to the Complaints Committee; and require the Complaints Committee to do anything the committee or a panel may do under the *RHPA* except request the Registrar to conduct an investigation.[29]

When a review has been requested, s. 32 of the *HPPC* requires the college to provide the record of investigation and the documents and things upon which the decision was based. The code requires disclosure of this information to the parties with some exceptions as listed in s. 32(3). Additional information can be considered by HPAPB in conducting the review, however, and there is currently no expressed legal requirement for timely disclosure of this additional information.

The primary responsibility of HPARB is to review certain decisions made by college Complaints or Registration committees when requested. In its consultation document *Weighing the Balance*, HPRAC asked for public comment on the role and responsibilities of this tribunal and received information on the timeliness of HPARB reviews, hearings and decisions.

Consultation Input

The majority of consultation participants, especially members of the public, who commented on HPARB expressed concern about the length of time it takes to have a case heard, with some participants indicating that it often takes as long as 12 to 18 months. In addition, the time it takes to receive a decision from the board was a concern of many participants.

Several participants raised the issue of fairness. They pointed out that appellants are required to notify HPARB within 30 days if they want to appeal a decision of a Complaints or Registration Committee but that the board is not required to hear cases or provide decisions within a specified time frame. They argued that such process discrepancies are unreasonable and lack fairness and

[29] Subsection 35(1) of the *HPPC*

that the *RHPA* should be amended to require HPARB to review cases and provide decisions to the appellants within a defined time period.

In addition, a number of submissions raised the issue of disclosure of documents and the appropriate role of colleges at the review process. Some colleges were of the view that not to be able to make submissions as of right to HPARB was unfair. Some individuals commented that the HPARB process was intimidating for complainants and that there is the perception that HPARB sides with the colleges.

HPRAC Analysis

HPRAC met with the Chair of HPARB to discuss a number of issues and is pleased to note that the board has done much to address its backlog of cases so that more timely disposal of appeals is being accomplished.

The time it takes to schedule an HPARB review or hearing has been dramatically reduced in the past year. HPARB is currently scheduling and reviewing all cases in less than six months' time; some of the more straightforward cases are being heard in less than three months. These reductions in time have been made possible in part by changes introduced in Bill 25, the *Red Tape Reduction Act*. HPARB advises that, among other things, the changes permit it to establish its own rules of practice and allow one-person panels to hear cases.

In 1999, HPARB reviewed more complaint and registration matters than in the years 1997 and 1998 combined. By the end of 1999, it had doubled the rate at which hearings and reviews were scheduled and conducted. Forty-nine per cent more decisions were issued in 1999 than in 1998. The queue for a board review was reduced from 18 to 20 months to an average of 15.5 months.

These reductions in time were achieved by increasing the number of days that HPARB members worked by 18.8 per cent and by adding 1.5 more staff. The board also instituted a substantial number of administrative and adjudicative initiatives, created its first rules of practice, produced decision-writing guidelines, made substantial improvements to its disclosure process and addressed the education needs of its members.

HPRAC commends the board for its efforts in improving administrative processes and reducing its backlog of cases. At the same time, however, HPRAC suggests that the review process needs to be augmented to include college participation in the review as of right. The college is responsible for the conduct of the investigation and therefore ought to be given an opportunity to be heard before a decision is made respecting that investigation. In addition, as HPARB can require the Complaints Committee or a panel thereof to take certain action, it seems only fair to allow colleges to be heard before such a requirement is made.

It is important that the summary nature of the HPARB appeal process be both fair and flexible for all the parties involved in the review. To this end, HPRAC concludes that it is appropriate that the party bringing the appeal give notice in which the grounds of the appeal and the evidence to be relied upon are clearly stated. This change will help secure basic fairness to all parties by ensuring that all are aware of the issues being brought forward for review.

HPRAC supports full and timely disclosure of the material to be relied upon in the review, with the exception of documents the board may refuse to disclose according to s. 32(3) of the *HPPC*.[30] It is a matter of fairness that all parties have disclosure of any additional material not previously considered by the college committee so they can be prepared for a review hearing.

HPRAC Recommendation(s)

36. **That s. 29(4) of the *HPPC* be amended to include the college to whom the complaint was made as a party to a review with full rights and obligations.**
37. **That s.29 of the *HPPC* be amended to require that the party appealing a decision of a panel of the Complaints Committee give notice of appeal in which the grounds of appeal and the evidence to be relied upon are clearly stated.**
38. **That s. 33 of the *HPPC* be amended to require disclosure to parties in the review of new documents to be relied upon and those not protected under 32(3) at least 10 days before the review.**

Section 2: Discipline of Professional Misconduct of a General Nature

The discipline process of the *RHPA* is one of the most legalistic aspects of the regulation of health professions, dealing as it does with matters of professional misconduct. The legal context of the discipline process means it is best described as adversarial. It is structured so as to ensure a fair hearing.

For purposes of this review, HPRAC has determined that the major components of the discipline process are: (9) Power/Composition of Discipline Panels; (10) Parties; (11) Evidence; (12) Hearing Process; (13) Orders; and (14) Appeals

9. Power/Composition of Discipline Panels

Currently under s. 38 of the *HPPC*, a discipline panel consists of not fewer than three and no more than five members. At least two members of the panel must be public members. Accordingly, it is impossible for a panel to contain a majority of professional members unless the panel sits as a full panel with five members.

Consultation Input

Many of the submissions about the Complaints Committee apply to panels of the Discipline Committee. For example, the presence of public members was noted as being an important element of accountability. Similarly, it was submitted that if a discipline panel sat as five members, two of those members being public members should remain a requirement.

[30] The Board may refuse to disclose: (a) matters involving public security; (b) anything that undermines the integrity of the complaint investigation and review process; (c) financial, personal or other matters of such a nature that the desirability of avoiding their disclosure in the interest of any person affected or in the public interest outweighs the desirability of disclosing the matter; (d) anything that may prejudice a person involved in a criminal proceeding or in a civil suit or proceeding; or (e) anything that may jeopardize the safety of any person.

The submission by Mr. George Belza that accompanied the Arnt referral recommended having a majority of public members on discipline panels. A number of submissions felt that there should be greater public representation on panels of Discipline Committees or that members of the panel should be chosen at random from college members throughout the province. It was also submitted that members of the panel ought to have sufficient training and support to fulfil their roles.

HPRAC Analysis

HPRAC has previously commented upon the importance of the self-regulation model for governing the regulated health professions under the *RHPA*. Part of that model includes the right and duty of a member charged with professional misconduct to be judged by his or her peers. Accordingly, HPRAC is of the view that the current proportionality between public and profession members is important to maintain; i.e. that three of five members of a discipline committee be profession members.

10. Party Status for Complainants

Section 41 of the *HPPC* provides that the parties to a discipline hearing are the member against whom allegations have been made and the college.

Consultation Input

Some submissions did not support party status for complainants while others were in favour of this. On one hand, a number of submissions indicated that it was the colleges' job to prosecute, including representing the position of the complainant before the discipline panel, and that accordingly there was no need for the complainant to have party status. Other submissions commented that it was the responsibility of the college to represent the public interest and not the complainant as the hearing process was to protect the public.

It was also submitted that giving complainants party status would add to the complexity of a hearing, causing delays and more expense. In addition, some submissions raised the issue of fairness to the member if a complainant was given party status – it might look like two prosecutors instead of one.

On the other hand, a number of submissions supported giving the complainant party status for several reasons: to keep the complainant properly informed of the proceedings; to give the complainant some direct say in the decision-making process; to prevent the actual or perceived conflict of interest on the part of the college in "brokering of deals with a member to lessen the penalty"; and to recognize that a complainant has just as much at stake in a discipline case as either the public or the respondent member.

HPRAC Analysis

HPRAC considered the question of party status for complainants in its report on the complaints and discipline process for professional misconduct of a sexual nature. In that report, HPRAC

recommended that party status be afforded those complainants who wished to avail themselves of such status. While HPRAC recognized the right and duty of colleges to carry the prosecution at discipline hearings, it nevertheless also recognized that complainants in cases of professional misconduct of a sexual nature should have a right to participate in that hearing.

In cases of professional misconduct of a non-sexual nature, HPRAC concludes that many of the same reasons are valid. For example, giving the complainant increased access to information will lessen any perception of conflict of interest on the part of the college and improve college accountability and transparency.

HPRAC recognizes that there are two sides to the argument on party status and that each side has a number of valid concerns. More important, however, HPRAC is concerned with considering the means by which the process can be said to be balanced between the competing interests involved. At present, the discipline process is weighted in favour of the college and respondent member based on a discipline model premised, to a large degree, on the college's ability to represent both the public and complainant's interests.

It is clear from the submissions that the individual complainants do not perceive the colleges to be adequately representing their interests. It is important to recall that without the complainant, there would be very few occasions for discipline. The complainant's role in the system is vital if the system is to be effective. Therefore, any aspect of the system that diminishes the complainant's confidence will diminish public confidence in the system and compromise its effectiveness. At the same time, it is equally important to recognize that colleges have the major responsibility in prosecuting their members for professional misconduct.

Granting party status to complainants does not, in HPRAC's view, diminish professional self-regulation. Indeed, it is a recognition that for the colleges to effectively govern themselves it is essential that they partner with the public in order to achieve their public interest objective.

HPRAC notes that, in United Kingdom where complainants have party status in proceedings at professional conduct hearings, approximately one-third of complainants choose to exercise their party status and use their own solicitors.

The *HPPC* currently recognizes in s. 41.1 the potential for a non-party to participate in a hearing very much like a party. The question of such participation is left to the discretion of the panel. HPRAC suggests that giving party status to complainants is entirely consistent with providing a fair hearing to both the respondent and the complainant. Party status for the complainant allows for the possibility of his or her acceptance of the process and therefore an appreciation of its limits and goals.

By providing a 30-day time limit in which to indicate their intention to exercise party status, colleges and respondents will have appropriate information to assist them in the preparation of the hearing.

In addition, it is equally important to acknowledge that it is the college's responsibility to have carriage of the prosecution throughout the process. A complainant who chooses to exercise his or

her right to party status is only a party to the proceeding, not a co-prosecutor with the college. It is the college that is ultimately responsible for protecting the public from harm through, among other things, the discipline process.

Accordingly, HPRAC concluded that should complainants be granted party status, the *HPPC* must also provide that it is the college that has carriage of the prosecution. To further clarify this responsibility, HPRAC also concludes that the *HPPC* should continue only to provide the awarding of costs to the college where such an order for costs is made.

HPRAC Recommendation(s)

39. That s. 41 of the *HPPC* be amended to give complainants party status at discipline proceedings, including pre-hearing proceedings to arrive at statement of facts and joint recommendations for undertakings and/or orders, and that complainants be required to indicate their intent to exercise party status within 30 days of receipt of notification of the decision of the panel of the Complaints Committee if proceeding to the Discipline Committee.

40. That s. 27 of the *HPPC* be amended to require that the notice given to complainants also contain information about party status, their rights and duties accompanying party status, and their obligation to give notice of their desire to exercise that status within 30 days of receipt of the s. 27 notification.

41. The HPPC be amended to state that notwithstanding a complainant's party status, the prosecutorial responsibility rests with the college.

11. Evidence

A number of discipline hearing provisions of the *HPPC* deal with evidentiary issues concerning a range of matters, from disclosure of evidence to the applicability of the rules of evidence at hearings.

Consultation Input

Some submissions commented on the importance of proper and full disclosure of all evidence so as to allow members to properly defend themselves at a discipline hearing. Other submissions noted that s. 49 of the *HPPC* prohibits the *Statutory Powers Procedure Act*'s rules on the admissibility of hearsay evidence.

HPRAC Analysis

HPRAC concludes that there is nothing in the submissions to warrant recommending changes to the current evidentiary regime of the *HPPC* for disciplinary hearings. HPRAC notes that questions of evidence are usually case-specific and that the civil rules of evidence applicable to discipline hearings provide enough flexibility and fairness, including the admissibility of hearsay evidence, to make their replacement undesirable.

The HPRAC report on the complaints and discipline process for professional misconduct of a sexual nature recommended that certain testimonial mechanisms be employed in cases of alleged sexual abuse, such as screens, video and/or a support person. That recommendation turned upon the unique circumstances and vulnerabilities of complainants in these cases and mirrored the fact that the law in other areas, such as criminal law, utilizes special evidential mechanisms for victims of sexual abuse. Accordingly, HPRAC does not recommend extending those testimonial mechanisms to cases involving allegations of professional misconduct of a non-sexual nature, except to the extent that they would normally apply in cases of child witnesses, as presently provided for in the *Ontario Evidence Act*.

12. Hearing Process

The *HPPC* contains a number of provisions for conduct of the hearing itself. Evidence requirements are discussed in the previous section of this report. Other elements of the hearing process include the public aspect of the hearing and exclusion of the public, legal advice obtained by the panel, publication bans, panel participation and non-party participation.

Consultation Input

HPRAC received a number of submissions dealing with general process issues, such as the amount of time the hearing process can take, the expense associated with hearings, and the uses of ADR. One submission suggested that a fuller investigation of the decision-making process was required before it was possible to comment upon whether the *RHPA* had struck an appropriate balance between patients/clients, members and the college.

HPRAC Analysis

In HPRAC's view, the issues raised by members of the public deal substantially with the question of whether the hearing process is fair. Fairness ultimately must be judged by recourse to the whole process and not simply to one of its parts. Nevertheless, HPRAC does have a concern about the use of ADR at the discipline stage of the process.

ADR is a term that applies to a broad range of processes that go beyond the narrow procedures prescribed in legislation. In the discipline process, some colleges use the term to apply to pre-hearing negotiations between the college and the member aimed at arriving at an agreement of facts or a joint proposal for a penalty if the member agrees to a guilty finding.

HPRAC acknowledges that there may be valid reasons for using ADR at this stage of the proceedings. However, at the same time the use of ADR could well have a detrimental effect on the public's confidence in the college's discipline process. Care must be taken to ensure that when ADR is used, it is not abused. The best method to ensure that such abuse does not occur is to ensure transparency and accountability in its use.

In considering the role of ADR in the complaints process HPRAC recommended caution with an emphasis on transparency to ensure that accountability and public confidence are maintained.

HPRAC contends that caution is also appropriate for the use of ADR during the discipline process.

HPRAC Recommendation(s)

42. That the *HPPC* be amended to require that all ADR settlements be subject to review and approval by the panel of the Discipline Committee hearing the matter and that the settlement be published on the Register available to the public.

13. Orders

Subsection 51(2) of the *HPPC* provides several orders that a panel of the Discipline Committee may make upon finding a member has committed an act of professional misconduct. Those orders include: revocation; suspension; imposition of specified terms; reprimand; fine; reimbursement of college for funding of therapy and counselling in cases of sexual abuse; and posting of security if an order is made for reimbursement.

In addition, there are specific orders for professional misconduct relating to sexual abuse of a patient. If the member is found incompetent, the panel may order one or more of the following: revocation; suspension; or imposition of specified terms. Finally, a panel may make an order awarding costs, in part or full, to either the member or college.

Consultation Input

Submissions raised the question of whether there should also be compensation awarded when the member is found to have committed professional misconduct. Some submissions indicated that if sexual abuse victims received support, it would only be fair that victims of other types of misconduct received support as well. Other submissions indicated that complainants had recourse to the civil courts to receive compensation and that the professional discipline process should not be confused with civil process or civil remedies, including court awards or insurance settlements. A few members of the public suggested that the *RHPA* be amended to specify appropriate punishments.

HPRAC Analysis

HPRAC does not accept that awarding financial compensation to complainants is an appropriate function for regulatory bodies. Protection of the public from incompetent and/or unprofessional health care practitioners is its primary objective through the discipline process. As a practical matter, college discipline panels lack the experience and knowledge required to make compensation awards. Civil liability is a matter for the courts to decide, while professional accountability is a college's main concern. These two functions should be kept separate and distinct.

Funding for therapy and counselling for patients/clients sexually abused by a regulated health professional is viewed in a different light. This funding recognizes the special nature of sexual misconduct and its impact on patients and aims to restore the patient's psychological health.

The HPRAC report on the complaints and discipline process for professional misconduct of a sexual nature recommended that order guidelines be included in the *HPPC* to help give guidance to those involved with assessing the nature of the order to be made in cases involving professional misconduct of a sexual nature. HPRAC is of the view that the provision of order guidelines for professional misconduct of a non-sexual nature is also appropriate.

The articulation of clear order guidelines will address a number of important concerns.

First, by requiring a panel to specifically address a number of factors, accountability is increased through greater public awareness of the exact factors a panel used in arriving at its decision.

Second, protection of the public is enhanced because "public protection" must be expressly addressed in arriving at the order.

Third, equity is furthered as clearly articulated factors help ensure submissions made by the parties address the factors that will determine the order and through those submissions the panel will have had those factors "argued" before it.

Finally, the efficiency of the appeals process will be increased because appeal courts will have the ability to look at a panel's order in light of the legislated guidelines and assess the order against those guidelines.

HPRAC Recommendation(s)

43. That the order guidelines recommended for cases of sexual abuse be extended to include all cases of professional misconduct (refer to recommendations 8, 9 and 10 on p. 3 of Appendix B).

14. Appeals

Sections 70 through 71.1 of the *HPPC* provide rights of appeal to the Divisional Court on questions of law or fact or both. In hearing an appeal, the court has all the powers of the panel or HPARB that dealt with the original matter. In all cases, except those dealing with incompetence, incapacity and serious sexual abuse, an appeal "stays" or suspends the panel's order until the appeal is disposed of.

Consultation Input

Some submissions indicated that the appeal mechanisms provided for in the *HPPC* were adequate. Others questioned whether there should be an automatic stay of orders for professional misconduct once an appeal was filed with the court. As appeals to Divisional Court may take months – if not years – to be heard, a member can continue to practice in certain circumstances merely by launching an appeal regardless of its merits.

HPRAC Analysis

HPRAC is of the view that protection of the public from a member who has been found to have committed an act of professional misconduct is of paramount importance. As a result, procedural issues arising from an appeal of such a finding ought to be viewed primarily from the perspective of the public interest in protection from harm. Given the fact that the judicial review process can take many months or years to be concluded, it is not in the public interest to allow for an *automatic* suspension of a discipline panel's order while awaiting the outcome of that review. Accordingly, HPRAC has concluded that all discipline panel orders – regardless of the nature of the professional misconduct or behaviour – ought to take effect immediately despite any appeal that might be brought.

At the same time, however, HPRAC also recognizes that it is important to balance the need for public protection with the need to respect a member's right to appeal from a verdict which may, in the end, be found upon review to be unreasonable, or made without jurisdiction, or made in violation of a member's constitutional rights. Therefore, HPRAC has concluded that in cases dealing with professional misconduct, other than those concerning incompetence, incapacity or serious sexual abuse as defined in s. 51(5)2 i, ii, iii or iv, a member ought to be allowed to bring a motion in the Divisional Court seeking a suspension of the order pending appeal if the member can establish that his or her appeal has sufficient merit or is otherwise not frivolous and that the continuation of the order is not necessary in the public interest.

HPRAC Recommendations(s)

44. That s. 71 of the *HPPC* be amended to provide that any order of a discipline panel takes effect immediately despite any appeal.

45. That the *HPPC* be amended to allow a member who wishes to have the order suspended, the right to bring a motion before a judge of the Divisional Court to suspend the order pending appeal provided that: (1) the order does not relate to incompetence, incapacity or serious sexual abuse as defined in s. 51(5)2 i, ii, iii, or iv; and (2) the member can establish: (a) that his or her appeal has sufficient merit or is otherwise not frivolous; and (b) that the continuation of the order is not necessary in the public interest.

Section 3: Complaints and Discipline for Professional Misconduct of a Sexual Nature

The *RHPA* required that HPRAC report to the Minister on the effectiveness of each health profession regulatory college's complaints and discipline procedures with respect to professional misconduct of a sexual nature.[31]

[31] Subsections 6(2)(a)&(b) of the *RHPA*.

In keeping with this statutory obligation, HPRAC hired PricewaterhouseCoopers (PwC) in 1998 to undertake an evaluation of the effectiveness of these procedures, to assess the status of colleges' patient relations programs and to propose a framework for the evaluation of those programs. PwC submitted its 28-volume report to HPRAC in July 1999.

Additional input was made available to HPRAC through the public hearings held by the Special Task Force on Sexual Abuse of Patients (STF) appointed by the Minister of Health and Long-Term Care. In addition, HPRAC obtained input from the public on colleges' complaints and discipline procedures through its public consultation process for the Review of the *RHPA*.

HPRAC's separate report on the effectiveness of colleges' complaints and discipline process for professional misconduct of a sexual nature was submitted to the Minister in December 2000.

HPRAC Analysis

The findings and input point to a need to modify the complaints and discipline process so as to better serve the public interest as well as the complainant's interest. The following findings are noteworthy:

- 2.0 per cent of Ontario participants (adult males and females) in the PwC survey reported incidents of inappropriate behaviour/remarks involving health professionals in the past five years; 1.0 per cent reported incidents of sexual contact/touching;
- after the *RHPA* came into force, only one in three survey respondents reported being certain or somewhat certain about where to file a complaint regarding sexual misconduct of a regulated health professional;
- fewer than a quarter of those who report having been sexually abused by a health professional would file a complaint;
- disposal of complaints takes much longer than the 120 days specified in the legislation, and may sometimes take several years;
- combining data from all Colleges, about 6% of sexual misconduct complaints/reports are referred to a college Discipline Committee;
- complainants view colleges' complaints and discipline processes as legalistic, adversarial, complex, non-transparent and lengthy.

A list of the HPRAC recommendations to the Minister are contained in Appendix C.

It is clear that the handling of sexual abuse cases requires specialized understanding of the dynamics and effects of such abuse, as well as provision of support to ensure sensitivity and respect for complainants as their cases proceed through a college's complaints and discipline procedures. While the *RHPA* focuses on the public interest, more attention has to be paid to the needs of complainants. Without a trust and confidence in colleges' complaints and discipline processes, complainants cannot be expected to come forward and colleges cannot protect the public from the harm of sexual abuse.

HPRAC recognizes that sexual abuse of patients/clients by health professionals is a serious matter and that effectiveness in addressing and preventing such abuse is imperative. HPRAC has

proposed significant improvements to protect the public and maintains that these improvements can be achieved while upholding self-regulation of health professions.

The HPRAC recommendations aim to promote:

- prevention through deterrence and public education;
- sensitivity and respect for complainants through increased support for and involvement of complainants throughout the complaints and discipline processes;
- procedural fairness and greater disclosure of information to build public confidence in colleges' handling of complaints;
- inter-sectoral coordination for increased accountability of individual health professionals;
- performance monitoring and evaluation for increased accountability of colleges.

The HPRAC recommendations for the handling of complaints of a sexual nature are consistent with those for complaints of a general nature. Both sets of recommendations seek to make the complaints and discipline processes stronger and more responsive to the needs of complainants so as to encourage those with complaints to come forward and stay the course as the complaints proceed through the college's processes. The trust and confidence of complainants in the colleges' handling of complaints of any type are essential so that colleges can protect the public from the risk of harm by regulated health professionals.

As noted in the introduction to this chapter, individuals who have complained to colleges about sexual abuse do not have confidence in the complaints and discipline process and perceive the colleges to be in a position of conflict of interest in handling complaints of both a sexual and general nature.

HPRAC has made a number of recommendations to rectify this situation. In particular, it recommended keeping complainants and respondents informed of any delays in processing their complaint, and giving them more involvement in complaints and discipline processes by according them party status. HPRAC also made recommendations for increasing fairness; for example, permitting complainants and respondents to review and comment on the investigator's written record of their statements.

Measures for increasing accountability include restricting the use of ADR and requiring that all remediation components of settlements reached through ADR be noted on the public register. In addition, accountability would be enhanced through a performance monitoring system established for overall accountability to the Minister and public through HPRAC. This would also enable ongoing quality improvement of colleges' complainants and discipline procedures.

The recommendations for the handling of sexual abuse cases are carried over for the handling of complaints of a general nature, with the exception of the three recommendations that address the special dynamics and effects of sexual abuse. These are:

(a) Provision of support services for complainants in sexual abuse cases

The intimate nature of the physical and emotional contact between some health professionals and their patients/clients provides considerable opportunity for sexual abuse. The consequences for the patients/clients may include self-blame, lowered self-esteem, insomnia, depression, anxiety, fatigue, poor job functioning, and difficulties with intimacy and sexual functioning.

The patients most likely to be abused may be the least likely to report the abuse. There are enormous difficulties in laying a complaint against a health professional, especially those with whom the patient/client may have had a longstanding relationship or on whom the patient/client's life could depend. When patients/clients do come forward and file a complaint, they have been in a health care relationship where there is likely to have been a power differential in favour of the health professional. In addition, the patient/client may be vulnerable as a result of the power imbalance as well as his/her physical, emotional or mental state. Thus the need for special supports and greater sensitivity and respect on the part of colleges towards such complainants is essential.

(b) Alternative dispute resolution not be used in cases of "serious" sexual abuse

HPRAC views the use of ADR in cases of "serious" physical sexual abuse as problematic because of the inherent power imbalance between the complainant and the respondent health professional and the sense of vulnerability and potential for revictimization that can result. Physical sexual abuse is not a "dispute" to be resolved but a misconduct to be addressed. A matter of serious sexual abuse is very much a public protection issue that goes beyond a private matter between the health professional and the patient, and, as such, should not be resolved through ADR.

(c) Complainants be allowed to provide videotape testimony, testify behind a screen or in closed-circuit television, and/or be accompanied by a support person when testifying for the Discipline Committee.

HPRAC is aware that recent developments in the law of evidence and the evidential process now provide a number of remedies to deal with the stress and trauma of giving evidence. For example, both the *Criminal Code of Canada*, and the *Ontario Evidence Act* provide express provisions to govern cases in which testimony from a complainant would be aided with the use of screens, closed-circuit TV or videotape.

HPRAC accepts that the sections in the *Ontario Evidence Act* dealing with a minor's testimony are relevant and should be expressly adopted in the *RHPA* in cases of sexual abuse, regardless of the complainant's age. However, rather than give an automatic right to everyone to use a screen, closed-circuit TV or videotape, the situation should be assessed for each case by the panel hearing the case. There must be a balance of rights between the respondent health care professional and the complainant and that balance is best achieved by allowing the panel to make its decision after it has heard submissions on the use of such devices. This is in keeping with the

main purpose of the law of evidence, which is to ensure that the decision-maker hearing the case is afforded the best possible evidence in a fair and open hearing.

Similarly, HPRAC accepts that a support person of the complainant's choosing ought to be available during the hearing. However, the necessity of balance and ensuring a fair process means there may be occasions when the support person of first choice is not an appropriate choice; for example, where the support person is also a witness at the hearing. HPRAC concludes that the practical compromise of determining the need for special tools that was reached in the *Ontario Evidence Act* with respect to a support person is also appropriate to the college hearing process and recommends its express adoption in the Health Professions Procedural Code.

These exceptions are recognized because of the serious nature of all sexual abuse. The power differential between the patient/client and health professional, the reluctance of complainants to come forward, and the potential for revictimization of the complainant in the course of proceeding through a college's complaints and discipline processes make sexual abuse of patients by health professionals more difficult to address.

Chapter 7 Public Access to Information

This chapter deals with public access to information about regulated health professionals and the activities of colleges that have a mandate to regulate their members in the public interest.

An important aspect of a person's health care is having the information necessary to help him or her in the choice of a health professional. This goal can be achieved only if members of the public have appropriate, timely and relevant information on which to base their choices. In addition, they must also have confidence that the health professionals with whom they deal are being regulated in a way that protects the public from harm and provides high quality care and services.

At the same time, however, the regulatory system must provide an appropriate balance between the public's need to access information about a health professional and a health professional's right to have certain information kept confidential. Where there is an expectation of privacy, a clear public benefit must be established before this privacy is violated.

The *RHPA* principles of accountability and fairness are at the heart of the public access to information issue. These principles, however, compete with the value of or right to privacy. These competing principles and values need to be reconciled if a proper balance is to be achieved.

This chapter deals with two topics:

1. Provisions for Confidentiality of Information
2. Public Access to Information on the Register

1. Provisions for Confidentiality of Information

Section 36 of the *Regulated Health Professions Act* says that everyone involved in the administration of the *RHPA*, the *Drug and Pharmacies Regulation Act* and the profession-specific Acts must preserve secrecy with respect to all information – except information that is in the public domain or that directly pertains to:

- administration of the *RHPA* and profession-specific Acts;
- registration and other regulatory college proceedings;
- regulatory bodies in other jurisdictions, except mandatory reports of sexual abuse;
- administration of other Acts as specified in the *RHPA*, except mandatory reports of sexual abuse;
- information obtained by a police officer who is conducting an investigation in connection with a law enforcement proceeding, or who is gathering information likely to result in a law enforcement proceeding;
- information provided to those acting as legal counsel to a person who is required to preserve secrecy;

- information provided to another person with the written consent of the person to whom the information relates.

Consultation Input

Very few of those who responded in writing to the consultation document *Weighing the Balance* commented on the provisions in Section 36 of the *RHPA*. However, HPRAC did hear a wide variety of views concerning public access to information and a college's confidentiality obligations during discussion forums with regulatory college representatives and members of the public.

A number of participants said the current wording of Section 36 imposes such a high standard of confidentiality that it prevents colleges from making disclosures of any type unless expressly authorized by statute.

Some participants – while acknowledging the importance of maintaining a high standard of confidentiality – believed a more liberal and open system would benefit the public. Others expressed the opposite view. They said that keeping information confidential was of paramount importance in maintaining the integrity of college investigations, the complaints process, and privacy issues related to both college members and members of the public.

One idea discussed at length was that of having Section 36 changed to reverse the current onus by indicating that the only information that should not be readily accessible to the public is information that the *RHPA* or other laws expressly state must be kept confidential.

HPRAC Analysis

In dealing with the issue of confidentiality of information, it must be recognized that the *RHPA* is based on a number of underlying principles – such as accountability, with its implied transparency and fairness – that may compete with a person's *value* of privacy, if not his or her right to privacy.

The roundtable discussions with college representatives demonstrated that there are a number of legitimate reasons for keeping information confidential (e.g. to ensure procedural fairness and the effectiveness of college programs). However, it must also be recognized that too much or unnecessary secrecy can reduce trust in the regulatory system, and thereby hinder the colleges' mandate to regulate health professions in the public's interest.

HPRAC devoted considerable time and thought to the question of whether the current *RHPA* provisions on confidentiality are in the public interest. The Act contains numerous provisions that require colleges to make information available to individuals (e.g. public access to information on the Register, annual reporting obligations, open public council meetings, disclosure to complainants and respondents, the open discipline hearing process, and open appeal board reviews). Nonetheless, HPRAC maintains that greater transparency is required if colleges are truly to be held accountable to the public.

HPRAC has concluded that greater transparency and accountability can be achieved in a variety of ways. One way is amending Section 36 of the *RHPA* to indicate that the kind of information that should be subject to specific confidentiality or disclosure provisions under the Act is information of a "personal nature." Personal information is recorded information about an identifiable individual, including:

- information relating to the race, national or ethnic origin, colour, religion, age, sex, sexual orientation or mental or family status of the individual;
- information relating to the education or the medical, psychiatric, psychological, criminal or employment history of the individual or information relating to the financial transactions in which the individual has been involved;
- the personal opinions or views of the individual except where they relate to another individual.

It is the privacy of individuals, whether members of the public or members of the college, that should be protected – not practice, institutional or administrative information such as policies and financial information. HPRAC contends that personal information, including access to or protection of profession information, must be kept confidential unless subject to specific provisions under the *RHPA*.

Further, HPRAC contends that the right to privacy is not absolute. Instead, privacy should be balanced against the communication of information if it is in the public interest to do so. It may be appropriate to release information about a member of a college when an investigation, while not complete, nevertheless reveals that there would be a broader benefit to the public if the information were disclosed. Where there is a broad benefit to the public, the release of information should supersede the right to privacy.

For example, when there is a public outcry over media reports about police investigations of serious misconduct by a health professional, there is an expectation that the college is taking action to protect the public. However, at present the college can neither confirm nor deny that it is investigating the issue. Current *RHPA* "secrecy" provisions do not allow a college to disclose when asked any information to assure the public that the college is acting in its interests. HPRAC contends that it is sometimes preferable for a college to disclose appropriate process information (e.g. that the college is investigating a particular matter). This would give colleges the flexibility to communicate currently protected information where it is in the public interest to do so.

HPRAC therefore recommends that an additional exemption be added to Subsection 36 (1) of the *RHPA*. The amendment would permit the communication of limited personal information to any other person where it is in the public interest to do so.

HPRAC also suggests that removing the word "secrecy" in s.36 and replacing it with "confidentiality" would more accurately express the intention of the *RHPA*: i.e to keep information confidential where it is deemed important to do so. The word "secrecy" implies a closed and restrictive system and is not in keeping with the *RHPA* principles of accountability and public protection or with the language used in other legislation; i.e. the *Freedom of Information and Protection of Privacy Act*.

HPRAC Recommendation(s)

46. That subsection 36 (1) of the *RHPA* be amended to replace the word "secrecy" with "confidentiality" and to indicate that it is "personal information" that is the subject of confidentiality unless the disclosure of such information is specifically provided for in the *RHPA* (e.g. access to information about a member's professional practice through the Register).

47. That subsection 36 (1) of the *RHPA* be amended to include an additional exception to the confidentiality provisions to allow a college to confirm its actions dealing with a member if it is in the public interest to do so. The HPPC should also specify that the information released in these situations be limited to information necessary to address the public's needs.

2. Public Access to Information on the Register

Section 23(1) of the *Health Professions Procedural Code* (*HPPC*) requires a college Registrar to maintain a Register. This Register must contain:

(a) each member's name, business address and business telephone number;
(b) each member's class of registration and specialist status;
(c) the terms, conditions and limitations imposed on each certificate of registration;
(d) a notation of every revocation and suspension of certificate of registration;
(e) the result of every disciplinary and incapacity proceeding;
(f) where findings of the Discipline Committee are appealed, a notation that they are under appeal [when the appeal is disposed of, the notation must be removed];
(g) information that a panel of the Registration, Discipline or Fitness to Practise Committee specifies shall be included;
(h) information that is required to be kept in the Register in accordance with the by-laws [this gives colleges the ability to add to the Register more information than is currently specified in the *RHPA*].

The *HPPC* also provides that some of the above information be publicly accessible:[32]

- information described in (a) to (c) above [the Code provides that the Registrar may refuse access to a member's business address and telephone number if he or she has reasonable grounds to believe disclosure of the information may jeopardize the member's safety];
- information described in (d) relating to a suspension that is in effect;
- the results of every disciplinary and incapacity proceeding completed within six years before the Register was prepared or last updated,
  - i. in which a member's certificate of registration was revoked or suspended or
  - ii. had terms, conditions or limitations imposed on it, or in which a member was required to pay a fine or attend to be reprimanded or in which an order was suspended if the results of the proceeding were directed to be included in the register by a panel of the Discipline or Fitness to Practise Committee;

[32] Subsection 23 (3) of the *HPPC*.

- information concerning every disciplinary proceeding, completed at any time before the time the Register was prepared or last updated, in which a member was found to have committed sexual abuse[33] and the results of the proceeding;
- information described in clause (f) above, relating to appeals of findings of the Discipline Committee;
- information designated as public in the by-laws.

Consultation Input

Written submissions in response to *Weighing the Balance* contained few comments on the public's access to information. Representatives from a district health council recommended that public registers contain information about health professionals who lost their licences in other jurisdictions. A member of the public commented that when a physician moves from one province to another, his or her record should follow.

The most frequently raised issue was disclosure of information about alternative dispute resolution (ADR) settlements. There was no consensus on whether information related to ADR should be disclosed. A fuller discussion of ADR is found in Chapter 6 on Complaints and Discipline, pages 66-69.

The three colleges that responded to the issue of ADR said that there should be no disclosure of such settlements. Consumer advocacy groups argued that there should be disclosure. Associations, health organizations and district health councils had mixed views on disclosure. One participant suggested that ADR settlements be disclosed in aggregate or summary form but that personal identifiers, such as names and addresses, be omitted. Another participant suggested that the Ministry of Health and Long-Term Care should provide guidelines on the disclosure of ADR settlements.

In a roundtable discussion with representatives from regulatory colleges, participants said there was support for sharing anonymous information for education purposes. Public confidence and professional credibility were raised as issues. Some colleges were in favour of providing more information on individual ADR settlements because, in their opinion, it would lead to increased accountability.

Some participants raised the issue of how long information should remain publicly available on the Register. In the case of negotiated settlements/ADR, it was suggested that any undertakings made by a member should not remain on the Register after a member has fulfilled the undertaking.

HPRAC also had a discussion forum with members of the public, consumer advocacy groups and public appointees to the health profession regulatory colleges. Participants responded to focus questions on information requirements and making information available. They listed a range of information items – including qualifications, litigation history, complaints, disciplinary actions and peer reviews under way – as information necessary to make an informed choice of a

[33] Sexual abuse as defined in clause 1. (3) (a) or (b) of the *HPPC*: (a) sexual intercourse or other forms of physical sexual relations between the member and the patient; (b) touching, of a sexual nature, of the patient by the member.

health care professional. One consultation submission from a member of the public suggested a member's criminal record be accessible.

Participants suggested a variety of methods of making information available to the public, including 1-800 numbers, publications and the Internet. Some barriers were mentioned, including language issues, readability, difficulties in accessing college registers and problems experienced using the *Freedom of Information* legislation. Participants felt that information should be more aggressively publicized and distributed by a wide spectrum of organizations, including colleges, libraries, community information centres and health professionals.

To reassure the public that regulatory colleges are acting in the public's interest, some participants thought statistics on complaints and dispositions should be published. It was also suggested that an arm's length group should publish these statistics. Others suggested that cautions and/or admonishments should be published. Some participants also believed that ADR results should be published and that ADR should be used only in cases where relatively minor issues were involved.

HPRAC Analysis

A number of competing principles are involved in access to information. A college's accountability to the public and its public protection mandate must be balanced with fairness and privacy principles.

HPRAC asserts that the public must be able to make informed choices about their health care practitioners and that colleges are best positioned to provide key information about individual health professionals. In this regard, HPRAC notes that there is a growing trend in the U.S. to give consumers access to more information. For example, in Massachusetts the Board of Registration in Medicine established a Physician Profiles Project in 1996. Since 1997, consumers have been able to obtain Physician Profiles by visiting the Board's website.

As a result, members of the public are now able to quickly obtain background information on Massachusetts physicians. They can find what medical schools they attended, where they currently practice, what insurance they carry, whether they have a history of malpractice, and whether they have been disciplined by a board or by any hospital in which they might have practiced.

Other states also provide the public with disciplinary information about a health professional. In Arizona, interim orders for practice restrictions and final disciplinary actions that became effective in the previous 12 months are shown on the Board of Medical Examiner's website.

Although Ontario colleges may not have all the information that is accessible in some U.S. states (i.e. publications, awards, malpractice claims) they do have a great deal of relevant information that should be made available to the public.

For example, in addition to what is now required to be on the Register, more information should be available about outcomes from complaints and discipline proceedings. Such information

should be added to that which is currently on the Register. HPRAC is of the opinion that so long as college hearings and investigations incorporate mechanisms that ensure due process for health professionals, consumers should be able to have access to the significant results of the complaints and discipline proceeding. This will make the system more transparent and, thereby, build public confidence in the system. In addition, some consumers have said that such information may assist them to make informed decisions on their choice of a regulated health professional. HPRAC is of the view that such information may at minimum assist them to verify the competency of a health professional.

HPRAC acknowledges that the new regulatory system set out in the *RHPA* aimed to increase access to health *professions* within a range of safe options. The objective of accessibility was not extended to individual health *professionals*. While this extension may have merit, HPRAC has concerns about the quality and validity of some of the available information when used as an indicator of the quality or calibre of a health professional. Further, consumers will vary in their views as to what information is relevant.

HPRAC Recommendation(s)

48. Subsection 23(3) be amended to require a college to include the following additional information in the publicly accessible part of the Register:

(a) Complaints Committee decisions resulting in a referral to the Discipline or Quality Assurance Committee.

(b) Information about voluntary undertakings related to remediation and limits on practice, whether negotiated through ADR, Complaints, Discipline or Quality Assurance Committee processes; the information to remain on the Register for one year or until the undertaking is completed (whichever is longer). This provision should not apply to undertakings related to incapacity issues.

(c) Information about cautions issued to a member, as well as the nature of the member's actions that resulted in the caution; to be removed from the Register after one year following the issuance of the caution if no further cautions have been given to the member.

(d) Information about all reprimands, fines and suspension/practise limitation orders issued in connection with disciplinary proceedings and the nature of such reprimands, fines or orders for suspensions or practice limitations. This information should remain on the Register for six years. This removes the discretion from subsection 23 (3) 3. of the Code.

(e) That the Minister direct a process with consumer groups and colleges to explore expanded collection and publication by colleges of such as information on:

- **special areas of practice or competency;**
- **specialty certificates; and**
- **malpractice information.**

(f) That the Minister require by policy that public information on college Registers be accessible via the Internet by January 2006.

49. That s. 23(1) of the HPPC be amended to require the Register to contain a record of every complaint and report filed with the college and the disposition of the complaint and report.

Chapter 8 Quality of Care

Under Section 6 of the *RHPA*, HPRAC is required to undertake an evaluation of colleges' quality assurance (QA) programs and report to the Minister of Health and Long-Term Care on the effectiveness of these programs. In keeping with this statutory requirement, HPRAC hired Harry Cummings and Associates (HCA) in January 1999 to conduct the evaluation. HCA's report, *Final Report on the Evaluation of the Quality Assurance Programs of the Ontario Colleges of Health Professions,* was submitted to HPRAC in July 2000. HPRAC's report to the Minister is dated October 2000.

The HPRAC recommendations of October 2000 were based primarily on the findings of the HCA report but also on input from the public consultation submissions on the *RHPA* review. HPRAC made ten recommendations to the Minister focusing on the full development of QA programs, building of college expertise in evaluation, and development of a performance monitoring system as the basis for future evaluations. These recommendations are included in Appendix B.

This chapter relates primarily to the principles of accountability, quality of care and protection from harm. It provides a summary of HPRAC's October 2000 report and is divided into two main topics:

1. Colleges' Quality Assurance Programs
2. Practice Setting Quality Assurance

1. Colleges' Quality Assurance Programs

Quality assurance is one of the four public interest principles put forward by the Health Professions Legislation Review. That review specifically noted the importance of instituting mechanisms for encouraging high quality care and recommended that there be profession-specific quality assurance programs for this purpose. Mandatory Quality Assurance Programs is one of the innovative and proactive features of the *Regulated Health Professions Act* and has served to position Ontario as a leader in the regulation of health professions.

Colleges are required to establish QA committees and make regulations prescribing a QA program. The *RHPA* defines QA as: "a program to assure the quality of practice of the profession and to promote the continuing competence among members." All college members are required to participate in the QA programs and cooperate with the QA assessors appointed by colleges.

Although the *RHPA* did not define detailed parameters for college QA programs, the Ministry of Health and Long-Term Care developed guidelines and principles upon which the QA programs were to be based. The ministry stipulated that the goals of QA programs should be two-fold: improved quality health care provision and improved patient outcomes.

HCA noted that there is no "ideal" model for QA programs specifically for health professions. Therefore, it identified elements of QA programs from the literature and from colleges' experiences and constructed a model QA program. The resulting model provided the basis for a

comparative assessment of each college's QA programs. This model was agreed to by all of the colleges at the outset of the evaluation.

The evaluation of colleges' QA programs comprised two components: college-specific evaluations as conducted by colleges and a meta-evaluation; that is, a composite evaluation of college-specific evaluations. The meta-evaluation consisted of an integration and analysis of findings from the review of colleges' QA programs and college-specific evaluation plans and implementation.

Current Status of Quality Assurances Programs

HCA Findings

The HCA report indicates that all but one of the colleges demonstrated they had developed the six elements of the model QA program, at least in part. Four colleges have fully implemented all six of the following elements:

- practice assessment (e.g. random on-site or off-site practice reviews by peer assessors, review of patient records by QA assessors);
- continuing competence (e.g. continuing education and professional activities, self-assessment and professional portfolio or improvement plans);
- general review and enhancement of profession (e.g. newsletters, website, journal publications, information sessions);
- standards of practice (e.g. code of ethics, core competency outline, practice guidelines);
- entry-to-practice requirements (e.g. entrance exam); and
- individual practice enhancement and remediation (e.g. outline of recommended remediation activities).

The HCA report noted a number of challenges colleges have experienced in the development and implementation of their QA programs:

- delays in getting QA regulations passed by the Ministry of Health and Long-Term Care;
- limited financial and human resources to devote to QA programs;
- resistance and anxiety among some college members in complying with QA programs;
- the need to develop innovative strategies for program delivery because of variation in the scopes of practice and practice settings within some professions, as well as to provide programs such as continuing education for practitioners in remote areas;
- newer colleges have had to devote considerable time and resources to establishing completely new QA programs;
- turnover in the membership of QA committees; and
- implementation of QA programs during a period of intense change in the health care environment.

Despite the short time colleges have had for the development and implementation of their QA programs, many have adopted innovative approaches.

HPRAC Analysis

HPRAC regards profession-specific QA programs as one of the most critical and innovative aspects of the *RHPA* in supporting high quality health care in Ontario. HPRAC knows that colleges would benefit from having a forum to showcase their unique approaches for themselves, other jurisdictions, major health care employers and the public. The HCA report notes that colleges have shared programs among themselves through the Federation of Regulatory Health Colleges of Ontario. Continued sharing of information may be strategic in strengthening the accountability of colleges for developing and implementing quality QA programs, as well as in building good relations and trust with the public.

Development of QA Program Components and Member Participation

HCA Findings

The HCA report identified the need to define linkages between essential QA program components to increase the model's effectiveness by ensuring synergy among the components. For example, standards of practice should be used to inform course content and other requirements for continuing education components. Data collected from practice assessments and remediation activities should be used to improve standards of practice. Evaluation data from one component can be used to strengthen another component which, in turn, can lead to an overall improved QA program.

The strength of the overall QA program depends not only on the effectiveness of each component but also on the extent to which the program components complement each other and are intertwined for greater impact.

Colleges have been proactive in building a variety of strategies to gain member commitment to QA programs, including:

- outreach to members through workshops, focus group meetings and articles in college newsletters and websites;
- member consultation such as surveys, needs assessments, and presentations by outside experts; and
- working with educational institutions to ensure that students are adequately trained and knowledgeable about QA expectations.

The HCA report supports these college strategies and recommends that colleges continue to enhance or strengthen member understanding and buy-in/commitment for their QA programs. Member buy-in is of particular importance because, as HCA's review of the QA literature indicated, skepticism among health professionals about the purpose and relevance of these programs is a major challenge in implementing QA programs, as are a lack of time and incentive for health professionals to participate in QA activities. Colleges have found their members to be particularly resistant to practice assessment, also known as peer review.

HPRAC Analysis

HPRAC contends that it is essential that all colleges fully implement all six elements of the model QA program, including practice assessments. It also contends that colleges must develop evaluation plans to assess the effectiveness of their QA programs to guide continuous quality improvements.

The Federation of Health Regulatory Colleges of Ontario has provided a valuable opportunity for colleges to share knowledge and expertise on the development of QA programs. Research findings on QA programs in broader health and other sectors are constantly changing, and it can be resource-intensive for each college to keep abreast of these changes on its own. HPRAC agrees that sharing information through an umbrella organization is an efficient way for colleges to remain current, and an effective way to learn from each other's experiences in implementing QA programs and promoting member buy-in.

Capacity-Building and Evaluation

HCA Findings

The HCA report highlights the importance of evaluating colleges' QA programs and hence colleges' capacity to conduct evaluations. The HCA evaluation has supported colleges in developing expertise in program development, implementation and evaluation. One important aspect of this learning process has been the identification of performance indicators to determine the impact of college QA programs.

The HCA framework document listed some initial indicators that have been particularly useful:

- percentage of members complying with various elements of the program;
- number and percentage of members calling the college for information on the QA program;
- number of members of the public seeking information on the QA program;
- members' compliance with practice standards;
- monitoring and tracking of patient complaints;
- percentage of members passing peer assessment;
- percentage of members for whom remediation is recommended; and
- patient/client satisfaction.

HPRAC Analysis

A major focus of the health professions regulatory system is protecting the public from incompetent providers and promoting continuing competence. The Minister of Health and Long-Term Care is responsible for administering this system and ensuring that colleges carry out their QA programs effectively. HPRAC evaluations and ongoing monitoring are key mechanisms for carrying out the Minister's responsibility.

HPRAC maintains that evaluation of colleges' QA programs should be seen as an ongoing process rather than a one-time undertaking. Evaluation should be based on a performance monitoring system and is an important undertaking for continuous quality improvement. Continued evaluation of the effectiveness of QA programs is beneficial to colleges and essential in ensuring that college QA programs improve the quality of care for the people of Ontario.

HPRAC recognizes that colleges have had a relatively short time in which to design their QA programs, develop QA regulations and get them passed by Cabinet, address implementation challenges, and develop specific evaluation plans within a common framework. It also recognizes the resource-intensive effort that colleges have put into the development of QA programs and the planning for evaluating these programs. HPRAC's analysis and recommendations have been mindful of the constraints faced by colleges, the accomplishments of colleges and the need for capacity-building for continuous quality improvement through monitoring and evaluation.

2. Practice Setting Quality Assurance

Problems within practice settings are currently identified by colleges during the course of a QA assessment or reported to colleges by health professionals who work in the particular practice setting. These problems can include faulty or improperly maintained equipment, inadequate resources and/or supplies, workload issues, and poorly designed workplaces and protocols.

Another broad system issue is that of unexpected adverse outcomes and errors; e.g. medical and medication errors. Many factors in the workplace affect the ability of the health professional to provide quality care. Such stressors as technological change and heavy workloads increase the risk of human error. These errors often occur in settings such as hospitals, where there are multi-disciplinary health professionals and institutionally-based policies and procedures. Patients/clients may or may not become aware of these errors. Sometimes errors come to light only when there is an unexpected adverse outcome or a coroner's inquest.

It is not always clear whether an adverse outcome is the result of error or, when an error is made, who should be held responsible for the error – the health professional, employer or facility. There is no review and thus there is no opportunity to learn from errors and no corrective action is taken to protect the public from risk of further harm.

Consultation Input

A total of 20 groups – including colleges, associations, educational institutions, district health councils and health care providers – expressed concerns that practice settings are having an adverse effect on health professionals' ability to practice according to the standards of their professions.

Colleges and associations question the ability of their members to follow the standards of practice for their professions when employers determine their working conditions. They indicate that workplace demands stemming from reduced resources due to downsizing, heavy caseloads, productivity requirements and other demands imposed by employers may be compromising the

ability of health professionals to provide quality care. This situation is a broad health system issue.

The majority of groups indicated that some additional authority or mechanism should be put in place to identify, report and resolve these practice setting issues. Eleven of the 20 groups felt colleges should be given the additional authority to identify, report and/or rectify deficiencies within the workplace. Only one organization, the Ontario Long-Term Care Association (formerly the Ontario Nursing Home Association), indicated that it did not support additional accountabilities or powers to the colleges to formally influence the work environment. The association felt there were already sufficient levels of accountability to address the provision of safe, effective and quality care and services in long-term care facilities.

The Ontario College of Pharmacists indicated that it would like the authority to inspect/regulate hospital pharmacies as it has the authority to do for all other pharmacies. It argued that licensing both the facility and the health care professionals would provide the accountability necessary to protect the public.

The College of Nurses acknowledges that practice setting issues are outside the jurisdiction of any one college; they involve multiple health care professions and various legislation and have an effect on both regulated and unregulated providers. They also highlight the fact that some practice settings – such as retirement homes and group homes – are subject to no legislation.

The College of Nurses suggests that the *RHPA* should require colleges to notify the Minister of Health and Long-Term Care of extraordinary situations where public safety is *seriously* threatened and place an onus on the Minister to provide appropriate and timely action and/or enforcement. The college recommends that criteria be developed to define the type of situation (e.g. severity, frequency of problem) that would require colleges to report to the Minister.

The Ontario Association of Medical Radiation Technologists argued that the employer controls their practice and therefore dictates the standards of practice to the employee. The association indicated that medical radiation technologists find themselves increasingly using outdated or under-serviced equipment and third-class supplies. In addition, they struggle with no support due to lack of staffing and an erosion of competency because of job assignment decisions.

This association argued that the colleges need the power to investigate and hold the employer accountable. The association also favours a whistle-blowing provision to protect members who report deficient practice settings to their college.

HPRAC Analysis

A number of mechanisms currently in place allow or oblige health professionals to report unsafe conditions, harm to patients or quality of care issues. For the most part, these mechanisms apply to publicly funded institutions/facilities and pharmacies. There are no comparable safeguards in place in private facilities (rehabilitation and physiotherapy clinics, optical dispensaries, etc.).

The mechanisms that apply to publicly funded health care institutions and pharmacies are as follows.

1. ***Public Hospitals Act***

The general view is that the hospital board is responsible for ensuring the quality of care received by patients within its facility. Under the *Public Hospitals Act*, each hospital board must appoint a Medical Advisory Committee to: [34]

(a) make recommendations to the board concerning:

- the quality of care provided in the hospital by the medical, dental and midwifery staff;
- the quality of care provided in the hospital by members of the extended class nursing staff with respect to the ordering of diagnostic procedures; and
- the clinical and general rules respecting the medical, dental, midwifery and extended class nursing staff, as may be necessary in the circumstances; and

(b) supervise the practice of medicine, dentistry and midwifery in the hospital and supervise the ordering of diagnostic procedures by members of the extended class nursing staff.

Furthermore, subsection 10 (1) indicates that an inspector may enter the premises of a hospital to make an inspection to ensure that the provisions of the Act and Regulation 965 under the *Public Hospitals Act* are being complied with.

2. ***Charitable Institutions Act***

Subsection 9.1 indicates that an approved corporation maintaining and operating an approved charitable home for the aged shall ensure that a quality management system is developed and implemented for monitoring, evaluating and improving the quality of the accommodation, care, services, programs and goods provided to the residents of the home.

Subsection 10.1 (2) indicates that an inspector may enter and inspect an approved charitable home for the aged to determine whether there is compliance with the Act and its regulations.

Subsection 12.12 (1) indicates that the Lieutenant Governor in Council may make regulations governing the treatment, care and discharge of residents of approved charitable homes for the aged.

[34] Section 35.1 of the *Public Hospitals Act*.

3. *Homes for the Aged and Rest Homes Act*

The *Homes for the Aged and Rest Homes Act* ensures that a quality management system is developed and implemented for monitoring, evaluating and improving the quality of the accommodation, care, services, programs and goods provided to the residents of the home.[35]

The Act also provides for an inspector to enter a home to determine whether there is compliance with the Act and its regulations. The inspector provides a written report to the municipality maintaining or operating the home or to the board of management of the home.

4. *Independent Health Facilities Act*

Subsections 7 (10) and 18 (2) of the Act contain provisions that allow the Director of Independent Health Facilities, who is appointed by the Minister, to suspend or revoke the licence of an independent health facility (IHF) if it is being operated in a manner that poses an immediate threat to the health or safety of any person.

The Director has the authority to direct inspectors to investigate an IHF to ensure that the Act and its regulations are being complied with. The College of Physicians and Surgeons of Ontario (CPSO) has a legislative mandate to perform quality assessment and inspection functions, including developing clinical practice parameters and facility standards for the delivery of medical services within IHFs. The CPSO's responsibilities include:

- assessing the quality of care when requested by the ministry;
- investigating the illegal charging of facility fees by unlicensed facilities (when requested by the ministry);
- monitoring service results in facilities (facility operators are required to establish and maintain a system to ensure the monitoring of the results of the services provided in a facility);
- providing education and assisting facilities to continually improve the services they provide to patients.

5. Community Care Access Centres (CCACs)

CCACs were established under the *Long-Term Care Act* to coordinate access to many community health care services. In addition to providing information and referral services and coordinating placements in long-term care facilities, CCACs purchase nursing, therapy and personal support/homemaking services for their clients from local service provider agencies. Services are provided to the CCACs' clients at home or in schools in accordance with the school health support services program.

[35] Section 19.6 of the *Homes for the Aged and Rest Homes Act*.

> The contracts between CCACs and the service provider agencies describe the standards for service provision and outline remedies for failure to perform in accordance with the standards. The service standards rely heavily on the *RHPA*. There are two key exceptions: social workers (who are now governed by the College of Social Workers) and personal support workers/homemakers. In the case of personal support workers/homemakers, the standards of service are highly developed within the contracts negotiated by each CCAC and the service provider agencies.

Based on the submissions, it is not clear to what extent the above-mentioned provisions are known or utilized. Furthermore, it is not clear whether these mechanisms could or would apply to colleges (as opposed to individual health professionals).

However, there is nothing in the legislation that specifically prohibits colleges (or anyone else) from reporting serious situations to the administrator/director of a particular institution or facility and bringing these to the attention of the Minister of Health and Long-Term Care.

Medical and medication errors could be reported by individual health professionals to the college of the member believed to have committed such an error. However, this reporting is not mandatory. Also, it may not always be clear which health professional, employer or facility is responsible; for example, in the case of medication errors.

The consequences of these errors can be serious. The College of Nurses of Ontario, in its *Communique* (June 2000, Vol. 25, Issue 2), notes that medication errors are "a very serious problem of sophisticated health care systems in many parts of the world" (p.6) and that "in Ontario, there is no system for collecting and analyzing data on medication errors" (p.7).

Some participants in the Review also noted that some health care delivery errors have serious consequences for patients and/or their families but there is no system in place for redress nor for corrective measures to prevent recurrence of those errors.

Several U.S. initiatives are under way to address medical errors. For example, the Joint Commission on Accreditation of Healthcare Organizations requires that, to maintain their accreditation, hospitals must report all unexpected permanent loss of function in patients and unanticipated deaths, as well as causal factors.

HPRAC is of the view that mechanisms for dealing with quality of care in different health care settings such as hospitals and long-term facilities are outside of the scope of the *RHPA*. The role of the college is to regulate the practice of a particular profession in the interest of the public. Giving colleges authority over identifying, reporting and/or rectifying practice settings would go well beyond their current mandate under the *RHPA* and perhaps even overlap or conflict with the mandate of ministry programs and other statutes. This situation could lead to confusing jurisdictional responsibilities.

Workplace QA issues often involve the actions and responsibilities of people not regulated under the *RHPA*, such as facility owners, other employers and unregulated health care providers in both private and publicly funded services outside the jurisdiction of any one college. HPRAC does not recommend that the *RHPA* be the vehicle to address general quality of care issues throughout the

health system in Ontario. Instead, it maintains that a task force should be established by the Minister to look into quality assurance issues that are beyond the scope of the *RHPA*.

Health care delivery errors, while unintentional, can be serious enough to result in disabilities and death. A continuous quality improvement system needs to be established to track errors, examine the contributory factors and determine ways of preventing such errors in the future. A task force on system errors should explore and determine an appropriate definition of reportable errors. It should also determine ways of :

- encouraging reporting;
- requiring disclosure to patient/family and central authority/agent;
- developing the capacity to investigate and identify system and human factors that contribute to errors;
- maintaining a central database to identify more common errors; and
- resourcing ongoing study of initiatives in other relevant jurisdictions to facilitate knowledge transfer.

HPRAC Recommendation(s)

50. That the Minister establish a task force to develop a system for reporting and dealing with the health care delivery errors that result in significant adverse patient/client outcomes and prevention of future errors.

Chapter 9 Patient Relations

Under Section 6 of the *RHPA*, HPRAC has a statutory obligation to report to the Minister of Health and Long-Term Care on the effectiveness of each college's patient relations program five years after the Act comes into effect. HPRAC also has an ongoing statutory duty under section 11(2) to monitor each college's patient relations program and to advise the Minister about its effectiveness.

During the fiscal year 1998-99, PricewaterhouseCoopers (PwC) conducted a descriptive study to determine the status of colleges' patient relations programs. This study was done in conjunction with the HPRAC evaluation of complaints and discipline processes for professional misconduct of a sexual nature.

Subsequently, HPRAC hired Harry Cummings and Associates (HCA) to conduct the evaluation of colleges' patient relations programs. The evaluation focused on the *likelihood* of effectiveness of their patient relations programs, in anticipation that a comprehensive evaluation will be undertaken later when performance indicators have been developed and agreed upon by all colleges. The current evaluation was completed in February 2001. HPRAC, at time of writing this report, is developing its advice for the Minister and will submit its recommendations in a separate report in March 2001. This Review Report is informed by the evaluator's observations.

Status of Colleges' Patient Relations Programs

The *RHPA* requires that all colleges regulated under the Act develop a patient relations program by December 31, 1994. The *Health Professions Procedural Code (HPPC)* of the *RHPA* defines this as "a program to enhance relations between members and patients." [36]

Under the *RHPA*, the patient relations program must include measures for preventing or dealing with sexual abuse of patients, including:

- educational requirements for members;
- guidelines for the conduct of members with their patients;
- training for the college's staff; and
- the provision of information to the public.

Further, colleges must provide funding for therapy and counselling for persons who, while patients, were sexually abused by members.

The purpose of the provisions in the Act related to sexual abuse of patients by members is to encourage the reporting of such abuse, to provide funding for therapy and counselling for patients who have been sexually abused by members and, ultimately, to eradicate the sexual abuse of patients by members through effective education, guidelines, and handling of sexual abuse when it is reported.

[36] Subsection 1(1) of the *HPPC*.

The colleges' patient relations programs have few components and are small in scale compared to their complaints and discipline procedures and quality assurance programs. All colleges have some form of a patient relations program that includes measures for preventing or dealing with sexual abuse, but they have implemented this legislated requirement to differing degrees. All colleges have some form of member education, public information, staff education or guidelines for conduct. In addition, all colleges have a fund for therapy and counselling. The process for accessing those funds varies among colleges.

Of all aspects of the patient relations programs, the most challenging for colleges is provision of education for the public. The public is a large group with diverse characteristics, information needs and access points. According to the 1999 survey, only one in three respondents reported being certain or somewhat certain about where to file a complaint regarding sexual misconduct of a regulated health professional. The *RHPA* provides a framework, not guidelines, and therefore does not elaborate on providing information to the public. Currently, the information colleges make available to the public may be provided upon request or proactively.

All colleges have a Patient Relations Committee. However, many patient relations activities are not undertaken under the direction of the Patient Relations Committee. In some colleges, such activities are undertaken by different areas of a college, so there is little if any need for a Patient Relations Committee.

HPRAC Analysis

Scope of Patient Relations Programs

HPRAC maintains that patient relations programs should have a broader focus than just sexual abuse. The purpose of such programs should fundamentally be enhancing relations between health professionals and patients – as well as enhancing relations between patients and the colleges. Effective professional:patient communications, respect, sensitivity to cultural diversity, and consent to treatment are examples of other true patient relations matters.

Properly instituted patient relations programs support the main legislative objectives of the *RHPA* (quality of care, public protection, and accountability) and can play an important role in preventing sexual abuse before it occurs. Patient relations programs in conjunction with public awareness campaigns can also strengthen the role of the public and individual patients/clients in working with the colleges towards effective regulation of health professions. HPRAC is of the view that colleges and the public have a partnership in regulating health professionals. The colleges' capacity to protect the public is highly dependent on the public's input by way of inquiries, complaints, and interest in college activities and outcomes. Not enough attention is being paid to supporting the public in this role.

HPRAC is also concerned that s. 84(2) of the *HPPC* requires colleges' patient relations programs to either prevent sexual abuse *or* deal with sexual abuse. Such wording makes prevention programs optional. HPRAC is of the view that it is in the public interest to oblige colleges to

have a prevention component to their patient relations program. According to PwC, only 14 colleges have a program that prevents *and* deals with sexual abuse.

Patient relations programs may extend beyond sexual abuse prevention. College objects include developing, establishing and maintaining programs to help people exercise their rights under the *RHPA* and the *HPPC*.[37] The *HPPC* also directs colleges that they have a duty to serve and protect the public interest.[38] In carrying out this duty, colleges may undertake to educate members of the public on any other issues that may protect them from harm or on making effective use of college processes to exercise their rights under the *RHPA*.

While the patient relations function is important in the health regulatory system, HPRAC recognizes from the evaluation findings that having a Patient Relations Committee is not essential for the fulfilment of this function. As discussed in Chapter 5 on p. 50, HPRAC contends that colleges should be allowed flexibility in how they choose to structure themselves for the planning and implementation of patient relations activities. Since HPRAC has a statutory responsibility to monitor colleges' patient relations programs, it maintains that the *RHPA* could be amended to allow colleges this flexibility. The need to ensure fulfilment of the patient relations function would be sufficiently addressed through requirement of this function in the *RHPA* and through ongoing monitoring by HPRAC. This recommendation is made in Chapter 5 on College Governance, p 51.

Public Education

Colleges have been collaborating through the Federation of Health Regulatory Colleges of Ontario to develop public education materials, such as a brochure on the role of colleges. The federation is an efficient mechanism for this approach because it avoids duplication of efforts. However, statutory responsibility for public education as an integral aspect of patient relations remains with each college. Some colleges, however, have experienced resistance from their membership over college activities to distribute material promoting a person's right to inquire or complain about a professional's conduct.

The PwC report raised the question of the responsibilities of the Ministry of Health and Long-Term Care for funding public outreach/education. It noted that the Federation of Health Regulatory Colleges of Ontario approached the government in 1994 about educating the public. The ministry's position was that there was no funding available for public education.

While colleges have a responsibility to educate the public, HPRAC contends that it is not appropriate for health professionals alone to be responsible through college membership fees to pay for public education related to broad societal issues. Further, HPRAC maintains that outreach to the public should not be the sole responsibility of the colleges. Given the magnitude and required expertise for this endeavour, HPRAC asserts that it is appropriate for the Ministry of Health and Long-Term Care to take the lead in ensuring that the public is made aware of its basic rights and remedies under the *RHPA*. A fuller discussion on public education is presented in Chapter 10 on Roles and Responsibilities, p. 105.

[37] Subsection 3(1) of the *HPPC*.
[38] Subsection 3(2) of the *HPPC*.

Member Education

PwC conducted a survey of college members that included questions on the education of members. Members stated that they find college bulletins/newsletters very informative. Yet the PwC report indicated that members have only a moderate level of familiarity with legislative requirements (PwC report, Vol. 3, p. 6). Many member education activities were one-time initiatives; for example, on mandatory reporting and boundary violations.

A large number of members indicated that knowledge of the legislation has not influenced their behaviour with patients (64 per cent) or colleagues (75 per cent) (PwC report, Vol. 3, p.11). However, males, who have a high risk of sexually abusing a patient, were more likely to indicate that knowledge of the legislation had influenced their behaviour with their patients/clients. In addition, members of potentially high-risk professions (based on complaints to membership size rations), such as physiotherapists and chiropractors, were more likely than those of other professions, such as dietitians, pharmacists and medical laboratory technologists, to indicate that the legislation had had some influence on their behaviour with patients/clients (PwC report, Vol. 3, p. 32).

Without member education, meaningful prevention of sexual abuse of patients/clients cannot be achieved. Members of regulated colleges must be aware of the risk of sexual abuse that could be associated with their particular profession and practice setting. They must also be able to fulfil their professional duties and ethical responsibilities as well as the mandatory reporting requirements of the *RHPA*.

Based on the PwC report, HPRAC suggests that members are willing to take the time and effort to keep informed about ways and means of preventing sexual abuse of patients/clients, and that the majority of regulated health care practitioners are dedicated to providing the best ethical and clinical care possible to their patients.

HPRAC Recommendation(s)

Only a few recommendations are being made at this time. Additional recommendations for colleges' patient relations programs will be developed after completion of the analysis of the evaluation of these programs.

51. That subsection 84(2) of the *RHPA*, which requires colleges to prevent *or* deal with sexual abuse, be amended to require colleges to both prevent *and* deal with sexual abuse.

52. That s. 84 of the *HPPC* be amended to require that the program measures must be extended to areas of patient relations beyond those for sexual abuse.

HPRAC's separate report on patient relations will focus more specifically on public awareness issues.

Chapter 10 Roles and Responsibilities of the Minister of Health and Long-Term Care and the Health Professions Regulatory Advisory Council

The opening chapters in this report dealt with the roles, responsibilities and governance of the 21 regulatory colleges and the Health Professions Appeal and Review Board (HPARB). This chapter examines the roles of the Minister of Health and Long-Term Care and HPRAC as outlined in the *Regulated Health Professions Act*.

While Ontario's 23 regulated health professions are self-governing, the Minister, HPRAC and HPARB each play different but complementary and important roles to support accountability and ensure that appropriate checks and balances exist within the regulatory system. The effectiveness of the regulatory system as a whole depends on:

- the effective functioning of the colleges, HPARB, the Minister/ministry and HPRAC in fulfilling their individual roles and responsibilities;
- the effective cooperation, communication and joint actions of these bodies.

This chapter is organized as follows:

Section 1: Role and Responsibilities of the Minister
1. Promoting Public Awareness
2. Public Education Program Content
3. Enforcement
4. Relationship between Colleges and the Ministry of Health and Long-Term Care
5. Oversight and Monitoring
6. Collection of Data for Planning Purposes

Section 2: Role of the Health Professions Regulatory Advisory Council
7. Reviews of the *RHPA* and Profession-Specific Acts
8. Release of HPRAC Reports
9. Requests for Referral to HPRAC
10. Program Evaluations and Ongoing Performance Monitoring

Section 1. Role and Responsibilities of the Minister

Under the *RHPA*, the Minister of Health and Long-Term Care is responsible for the administration of the Act.[39] The Minister has the duty to ensure that the health professions are regulated and coordinated in the public interest; that appropriate standards of practice are developed and maintained; that individuals have access to services provided by the health professions of their choice; and that members of the public are treated with sensitivity and

[39] Section 2 of the *RHPA*.

respect in their dealings with health professionals, colleges, and the Health Professions Appeal and Review Board.[40]

The Minister also has specific powers under the Act and may:

- inquire into or direct a college council to inquire into the state of practice of a health profession in a particular area or institution;
- review a council's activities and require the council to provide reports and information;
- require a council to make, amend or revoke a regulation made under a health profession Act or the *Drug and Pharmacies Act*;
- require a council to do anything the Minister believes is necessary to carry out the intent of the *RHPA*, a specific health profession Act or the *Drug and Pharmacies Regulation Act*. [41]

The Minister's role is key to the effectiveness and accountability of the entire regulatory system. The Minister's powers ensure that the colleges can be held accountable for their actions and ensure the effectiveness of the regulatory system by providing for certain actions to be taken if colleges fail to meet their duties and responsibilities.

In the course of exercising the responsibility of administering the *RHPA*, the Minister – supported by ministry staff – carries out the following well-established functions:

- developing regulatory policy for legislation and regulations;
- processing regulations;
- overseeing and monitoring college activities and programs; and
- proposing and administering public appointments to college councils, HPARB and HPRAC.

The Minister may refer any matter concerning the regulation of health professions to HPRAC for its review and recommendations. When requested, HPRAC assists the Minister in regulatory policy development through referrals. HPRAC's role and responsibilities are discussed at greater length in the next section of this chapter.

In its public consultation document, *Weighing the Balance*, HPRAC asked participants to comment on the powers and responsibilities of the Minister as outlined in the *RHPA*. Comments centred on the following issues: public education, enforcement of *RHPA* provisions, and the relationship between the Minister/ministry and the regulatory colleges.

1. Promoting Public Awareness

Public education and access to information are the keys to an informed public, which in turn are absolutely vital to the effectiveness of the regulatory system. In effect, the system cannot be truly accountable to a public that is unaware of the basic elements of the system set out in the *RHPA*,

[40] Section 3 of the *RHPA*.
[41] Subsection 5 (1) (a) to (d) of the *RHPA*.

such as which professions are regulated and the right to have concerns about a health professional addressed by the professional's governing body.

Consultation Input

Only two of the 87 groups and individuals that addressed the issue of public education in their submissions to HPRAC believed the public was adequately informed or educated about the system of laws and bodies involved in the regulation of health professions. The remainder were of the opinion that – five years after the *RHPA* came into force – most health care consumers still know very little about the Act's provisions, the purposes and mandate of regulatory colleges, the standards to which regulated health care professionals can be held, and the public's right to complain to colleges about the conduct of their members.

Submissions from regulatory colleges – including those responsible for newly regulated professions – also expressed the opinion that the general public still has a limited understanding of the legislation, despite their efforts to inform the public about the *RHPA* provisions and the scope of practice and responsibilities of their members.

The majority of colleges believe that it is not feasible for any one college to provide effective and consistent public education about the *RHPA*. They believe the government – through the Ministry of Health and Long-Term Care – should be responsible for public education or that the ministry and regulatory colleges should share this responsibility. A small number thought colleges should have sole responsibility for public education, while others suggested that health professionals provide it in their practice settings.

Most colleges and some professional associations noted that the ministry has successfully demonstrated its expertise and ability to mount consistent, cost-effective public information campaigns (e.g., following the enactment of such legislation as the *Consent to Treatment Act*, the *Substitute Decisions Act* and the *Health Care Consent Act*). They pointed out that when the *RHPA* was introduced, the government made a commitment to mount a similar public education campaign. Many expressed disappointment that the ministry had not carried out its intended plan and said that it should use its expertise to fulfil its obligation to the public.

The issue of public education funding was also of great concern to individual members of the public. Consultation submissions from members of the public noted a perception that colleges do not adequately educate the public about the *RHPA* and the public's rights under the Act. One submission commented on the need for a "conspicuous communications strategy" to inform patients of their rights and how to make a complaint.

Many colleges believe the ministry should provide resources to help them educate the public about the *RHPA*. They pointed out that, while the Act does not specify who is responsible for funding public education, the ministry had set a precedent by funding other public education campaigns in the past.

The majority of professional associations felt the funding of public education should be shared by the colleges and the ministry, while most members of the public believed the ministry should pay for the development and distribution of public education materials.

HPRAC Analysis

HPRAC recognizes that the *RHPA* does not specify who has overall responsibility for informing the public about the regulatory system established under it – although the Act does stipulate that all colleges must have a patient relations program. The Act defines this program as one designed to "enhance relations between members and patients."[42] (Refer to Chapter 9 pages 103-106 for a discussion on patient relations programs.) At a minimum, the program should educate the public about what is, or is not, appropriate professional conduct and describe measures for preventing and dealing with sexual abuse of patients/clients. In addition, HPRAC notes that under Section 3 (1) 6 of the *Health Professions Procedural Code*, colleges are required to "develop, establish and maintain programs to assist individuals to exercise their rights under this Code and the *Regulated Health Professions Act*."[43]

Colleges do provide information to the public on an "as requested" basis – usually as part of a submission or inquiry about a complaint. However, few have information outreach programs that proactively provide the public with general information about the regulation of their members in Ontario; for example, through articles in popular magazines. Some colleges do educate the public about the scope of practice of the professions they govern, and educate their members about their responsibilities and obligations as regulated health professionals. The finding from HPRAC's evaluation of the complaints and discipline process related to sexual abuse, showing that only one in three reported being certain or somewhat certain about where to file a complaint regarding sexual misconduct of a regulated health professional, is suggestive of limited success in reaching the public.

Through the Federation of Health Regulatory Colleges of Ontario, colleges have also collaborated on the development of broader public education initiatives, such as developing a brochure about the regulatory system and providing college members with information pamphlets for display in the places they practice. Some colleges also have websites or public access to information via a 1-800 number.

HPRAC contends that the effectiveness of the regulatory system and the accountability of health professionals to the public are undermined if the public is not informed about the role of colleges in handling inquiries about health professions as well as other aspects of the regulatory scheme. A province-wide, ministry-led public education program that describes how health professions are regulated would be beneficial to the public, to regulatory colleges and to the ministry itself.

Although professional self-regulation suggests that colleges should be providing information to the public on the scope of practice of their respective professions, HPRAC is of the view that requiring each of the 21 colleges to inform and educate the public about the *RHPA* and the entire regulatory scheme is inefficient and ineffective.

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[42] Subsection 1 of the *HPPC*.
[43] Subsection 3 (1) 6. of the *HPPC*.

Given the resources and skills required, HPRAC maintains that the ministry is in the best position to provide and to coordinate – in consultation with the colleges – the development and delivery of consistent, accurate and timely information and education programs to the public. Furthermore, it is HPRAC's opinion that public education is entirely consistent with the Minister's role as outlined in the *RHPA*.

HPRAC notes that the ministry has played a key role in educating the public on several important legislative initiatives in recent years. In particular, HPRAC is aware of the ministry's role in leading, coordinating and implementing a comprehensive training and education initiative on mental health legislative reform. This initiative included the following components:

- regional information seminars across the province;
- the development and distribution of educational binders for stakeholders, users of mental health services and their families;
- professional development seminars for physicians and hospital staff; and
- staff seminars within the Ministry of Health and Long-Term Care.

HPRAC contends that a ministry-led public education initiative on the *RHPA* would help the public to:

- make informed choices about using regulated and unregulated health care providers for specific services;
- gain a better understanding of the roles, responsibilities and accountability of regulated colleges and the health professionals, and thereby increase their trust in the regulatory system;
- know who to contact about the conduct and performance of a regulated health professional and help colleges intervene with members whose conduct is inappropriate;
- make better use of information available through college registries and other sources;
- become better informed about "controlled acts" and *RHPA* provisions for protecting the public from harm, thereby ensuring more effective enforcement; and
- make unregulated health workers and those studying to become regulated health professionals more aware of the limits placed on them by the *RHPA*.

Overall, HPRAC strongly maintains that increased public awareness and education is the principal means of ensuring a more effective health profession regulatory system in Ontario. It should be noted that as part of its consultation process, HPRAC widely distributed a large number of copies of *Weighing the Balance*, which provided considerable information about the *RHPA*. This served to educate, on a onetime basis, a few interested members of the public on several important provisions in the Act. The *RHPA* highlights in *Weighing the Balance* could be used as a foundation for future public education initiatives undertaken by the ministry in collaboration with colleges. The print medium could be supplemented with other media, and public awareness campaigns must be sustained over time.

HPRAC Recommendation(s)

53. That the *RHPA* be amended to require the Minister in consultation with the colleges to be responsible for designing, implementing and funding ongoing effective education of the public.

2. Public Education Program Content

Consultation Input

Members of the public clearly stated in their submissions that there has not been provision of adequate information and education to the public. They recommended that all patients/clients be made aware of *RHPA* provisions and their rights and privileges under the Act. They specifically mentioned the need for better information about:

- the role and functions of regulatory colleges;
- the use of titles by regulated and unregulated professionals;
- the difference between regulated and unregulated professions and the public's right to access health professions of their choosing;
- the scopes of practice of regulated professionals;
- the limits placed on what health professionals can and cannot do under the *RHPA*'s "controlled acts" provisions;
- the complaints process and when and how to register complaints;
- certification and registration requirements for health professionals.

Participants suggested that this information could be delivered via:

- a central agency;
- a dedicated 1-800 number;
- one or more Internet websites;
- posters, booklets, pamphlets and flyers in hospitals, clinics, waiting rooms and all other practice settings;
- TV and radio programs or newspaper articles.

HPRAC Analysis

PricewaterhouseCoopers conducted a survey for the HPRAC report to the Minister on complaints and discipline procedures for professional misconduct of a sexual nature. Based on a representative sample of Ontario adults, this survey concluded that five years after the *RHPA* came into force, only one in three people reported being certain or somewhat certain about where to file a complaint regarding sexual misconduct of a regulated health professional.

HPRAC is of the view that such lack of knowledge about complaints and discipline processes may mean the public also is unaware or uninformed about other aspects of the regulatory system, such as the difference between regulated and unregulated health care providers, the risk of harm clause and the controlled acts provisions.

A province-wide public education program that describes how health professions are regulated would be beneficial to the public, to regulatory colleges and to the ministry. Members of the public need information on the nature of regulated versus unregulated health care services and their rights as the patients/clients of regulated health care providers.

HPRAC Recommendation(s)

54. That the *RHPA* be amended to specify that at a minimum the public education program referred to in recommendation 53 cover the following:

- **(a) which professions are regulated;**
- **(b) meaning of regulation – role of college and member requirements for QA, adherence to standards, entry to practice, controlled acts;**
- **(c) role of colleges to protect the public;**
- **(d) how to make inquiries about a profession or member of a college, and how to make a complaint;**
- **(e) the public's right to access information about a health professional.**

3. Enforcement

The goals and objectives of the *RHPA* can be achieved only if the legislation itself is effectively enforced. Given the various prohibitions outlined in the *RHPA* (e.g. the controlled acts regime, restricted titles, provisions for fines), it is clear that the Act was intended to have strong enforcement and that it was intended to apply to members as well as health care providers who are not members of any of the health profession regulatory colleges.

Consultation Input

Enforcement of the Minister's powers was an area of great concern to those who participated in the consultation. Most colleges and some professional associations believed the Minister should take an active role in enforcing the legislation, particularly in situations where unregulated health practitioners are performing controlled acts. Colleges, professional associations and health organizations also requested clarification and guidelines for the enforcement provisions.

About 25 per cent of the submissions from members of the public expressed concern over the issue of Minister/ministry and college powers, particularly with respect to the lack of enforcement powers under the *RHPA*.

HPRAC Analysis

It is HPRAC's understanding that, with the exceptions of member-specific enforcement by a college, some provisions of the *RHPA* are not being enforced on either a proactive or reactive basis. According to consultation feedback, the fact that the *RHPA* does not explicitly assign responsibility for enforcement has made it difficult to identify and deal with breaches of the Act by unregulated health care providers.

The effectiveness of the regulatory system depends upon effective enforcement. It is clearly in the public interest to have a strong regulatory system and that the *RHPA* provisions be enforced, especially those related to performance of controlled acts and the use of restricted titles. Failure to do so could pose the risk of endangering the public and producing a weak, ineffective regulatory system.

Furthermore, many health care services in Ontario are being delivered by non-members of regulatory colleges (i.e. unregulated health care providers). Unless enforcement activities extend to unregulated providers, the public is at risk of harm.

It is clear that colleges are responsible for enforcing the provisions of the *RHPA* and its regulations with respect to their members. However, it is not clear whether their enforcement powers apply to people who are not members of a college. This fact has substantial implications in situations that involve cross-profession provisions, such as the use of the "doctor" title, where professions share authority for controlled acts, and where the provisions are very general in nature (e.g. the harm clause and controlled acts exceptions).

Colleges have no clear jurisdiction over health care providers outside the profession(s) they govern and no authority to order such persons to do anything. The only concrete mechanism for enforcement is a judicial proceeding where a college, the ministry or another person is successful in obtaining a court order that forces someone to cease doing something or levies a fine as provided for in the *RHPA*.

Enforcement is an essential and critical function; it ensures the protection of the public from harm and the accountability of all parties within the regulatory system. However, to be effective, it needs to be done on a consistent and coordinated basis and people need to know where to report breaches of key public protection provisions of the Act. HPRAC is of the view that the *RHPA* clearly assigns the Minister the duty to "administer the Act"[44] and that this includes the responsibility to ensure effective enforcement of its provisions.

To clarify the current ambiguity, HPRAC strongly contends that there is a need to identify in legislation the Minister's responsibility for enforcement. At a minimum, the regulatory system needs to create a mechanism that will enable responses to reports about suspected breaches of the *RHPA* by providers who are not members of a regulated health profession.

This mechanism should also provide the authority and resources necessary to investigate, write cease and desist letters stating the consequence of continued breaches, and initiate legal action through the judicial system. This action may most frequently have to be applied to unauthorized people performing controlled acts or using protected titles, for the harm clause, and to employers who do not make mandatory reports.

HPRAC is also of the view that the ministry must have the capacity to handle reports of suspected breaches and that any public education initiatives undertaken must make this ministry function known to the public.

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[44] Section 2 of the *RHPA*.

HPRAC Recommendation(s)

55. That the *RHPA* be amended to clearly assign to the Minister of Health and Long-Term Care responsibility for enforcement as it would apply to non-members.

56. That the *RHPA* be amended to provide specific mechanisms that give effect to this responsibility, such as the creation of an enforcement capacity within the ministry (or a delegated body) that would handle reported issues, conduct investigations, issue cease and desist orders and initiate prosecutions as needed.

57. That the enforcement capacity/body be provided with adequate resources to effectively enforce the provisions of the *RHPA*.

4. Relationship between Colleges and the Ministry of Health and Long-Term Care

Colleges have a duty to govern their members in accordance with the *RHPA* and profession-specific Acts, and to serve and protect the public interest.[45] While fulfilling this role, colleges must rely on the Ministry of Health and Long-Term Care to develop regulatory policy, process regulations and propose/administer public appointments to college councils.

As mentioned, the Minister has a duty to oversee and monitor the colleges and ensure they are fulfilling their obligations under the *RHPA*. There is an inherent interdependence in this relationship. For example, the processing of regulations is one area in which the ministry and colleges interact on a regular basis. Regulations deal with issues of public protection (e.g. professional misconduct and member registration requirements). Therefore, the effectiveness of the college/ministry relationship has a strong influence on the effectiveness and efficiency of the regulatory system, its ability to protect the public, and the ability of colleges to govern the profession in the public interest.

Consultation Input

Participants in the consultation were concerned with the timeliness of Minister/ministry decisions and actions with respect to responsibilities under the *RHPA*. They frequently mentioned the length of time taken to enact regulations and legislative amendments, make referrals to HPRAC, and appoint public members to college councils.

The majority of participants expressed concerns about barriers to the timely passage of legislative amendments and regulations under the *RHPA*. At present, there are no service standards concerning timelines for processing proposed regulations. Submission feedback indicated that this has caused colleges to delay implementation of statutory requirements, such as quality assurance programs and changes to registration regulations that accommodate labour mobility as required under the Agreement on Internal Trade.

Regulatory colleges and professional associations believed that a streamlined process for processing new regulations and proposed amendments is needed. The public appointments process has been criticized for being slow and consequently hampering colleges' ability to

[45] Subsections 3 (1) and (2) of the *HPPC*.

function efficiently. Many participants said delays at the government level restricted colleges' ability to govern the professions effectively. These concerns were echoed in two submissions from members of the public.

While participants did not specifically recommend that the Minister and/or ministry have an increased oversight role, program evaluations have indicated that the Minister needs to support and develop the full potential and impact of the statutory programs (e.g. patient relations and quality assurance programs) in the *RHPA*.

HPRAC Analysis

Establishing regulatory policy and processing regulations are critical functions that only the ministry can perform. HPRAC is aware that some colleges are discouraged at the prospect of a lengthy process for approval of proposed regulations and are instead choosing to govern their members through the use of guidelines. HPRAC is of the view that guidelines are not highly enforceable and, as a result, this practice circumvents the intention of the *RHPA*, weakens the effectiveness of the Act and affects the ability of colleges to effectively govern their members.

HPRAC notes that the *Red Tape Reduction Act* did make some changes by moving some college authorities from regulation-making authority to bylaw-making authority. However, with one notable exception of incorporating standards of practice into regulation by reference, these were only for administrative matters.

HPRAC is of the view that the ministry needs to commit itself to service standards and assign the resources needed to perform its functions in a way that will reliably achieve these standards. This commitment would apply to the ministry's oversight and policy/regulations functions.

In its reports on the effectiveness of colleges' complaints and discipline procedures for sexual abuse cases and colleges' quality assurance programs, HPRAC indicated the importance of establishing a monitoring system and conducting periodic evaluations, among other things, as a means for increasing the ministry's capacity for oversight and follow-up. Further details on the proposed monitoring system and evaluations are provided below and further in this chapter on page 123.

HPRAC Recommendation(s)

58. That the Minister, in consultation with colleges, develop service standards that set reasonable timelines for carrying out functions such as processing and approving college regulations, making legislative amendments, and appointing public members.

59. That the Minister ensure those responsible for initiatives related to the establishment of service standards are provided with the resources necessary to achieve the desired outcome.

5. Oversight and Monitoring

HPRAC is of the view that there is a need for the Minister/ministry to:

- monitor on a regular basis how colleges are implementing *RHPA* provisions;
- develop specific mechanisms that hold colleges accountable for governing regulated professions in the public interest;
- support the colleges' self-governance mandate by developing and implementing efficient and reliable procedures for staying abreast of college activities through reports and program evaluations on such aspects as quality assurance and patient relations programs and the complaints and discipline process; and
- give timely guidance when college activities are not addressing the public interest in an optimal way.

Concerted efforts at oversight are essential to the effectiveness of the regulatory system. The oversight function is dependent on timely, insightful and meaningful information, hence the need for well-planned monitoring systems and periodic statutory evaluations. Large-scale monitoring and evaluation requires that college reports contain consistent, comparable and publicly accessible information, and that information requirements be specified by the Minister. This change would facilitate a greater accountability to the public through the Minister and the ministry.

Assuming a planned and proactive oversight role rather than a reactive crisis-driven oversight role would not mean the Minister was controlling colleges. Instead, in HPRAC's view, the Minister would be providing the necessary leadership and appropriate mechanisms to hold colleges accountable for their actions and to prompt them to problem-solve emerging challenges.

HPRAC Recommendation(s)

60. That the Minister, through policy and/or other directives, specify information for planning, monitoring and evaluation purposes that colleges are to provide in their annual and other specified reports.

6. Collection of Data for Planning Purposes

The Ministry of Health and Long-Term Care has a role in health human resources planning. This role is well established in relation to physicians and nurses and is now growing in relation to several other health professions.

At present, colleges collect and maintain information about their members so as to meet the statutory obligations of maintaining a register of members. The type of information they must maintain at minimum is specified in the *RHPA* (e.g. name, business address, specialist status). Colleges have the authority to make by-laws prescribing additional information to be kept on the Register and what additional information can be made available to the public. They also have the ability to charge fees for anything they are authorized to do, such as collect and provide aggregate information.

Consultation Input

Two district health councils indicated that colleges should be required to collect, maintain and make available certain data to support accurate health services planning in Ontario. Interest in amending the *RHPA* in this regard has also expressed by ministry staff involved in health human resources planning.

HPRAC Analysis

The issue of colleges being required to collect data for health human resources planning purposes was considered in relation to their mandate and the principle of efficiency.

HPRAC notes that colleges currently do not have a legislated mandate to undertake activities related to health human resources planning. However, section 3 (1) of the *HPPC,* which lists the objects of the college, would appear to permit such activities if the college council deemed them desirable or in keeping with duties imposed or conferred on them. The college mandate is very clearly focused on developing and maintaining standards and programs related to regulating the profession.

Colleges are well positioned to collect information, such as member demographics that may assist in planning. However, HPRAC is concerned that requiring all colleges to collect and prepare such information in useful planning formats would be an inefficient and costly way to secure planning information for district health councils and the ministry. It is estimated that as many as half of the 23 health professions are not subject to particular planning activities by district health councils, the ministry or other public interest groups; e.g. dentistry, opticianry, and chiropractic. It would be a waste of resources to require these colleges to collect, maintain and make available relevant planning information.

As an alternative, HPRAC is of the view that a more targeted approach is needed – one that first identifies the health professions that are the focus of formal planning activities. This would be followed by negotiation with those identified colleges to assess and make available appropriate resources for them to collect, maintain, and provide information in a format useful for planning. This requirement would recognize that generating planning information goes beyond the colleges' primary mandate and that they should be compensated adequately for the additional service and administration.

Section 2. Role of the Health Professions Regulatory Advisory Council

The role of the Health Professions Regulatory Council (HPRAC) is broadly defined in the *RHPA*. It is responsible for giving the Minister advice on:

- whether unregulated professions should be regulated;
- whether regulated professions should be unregulated;
- suggested amendments to the *RHPA*, profession-specific Acts or regulations made under any of those Acts;

- matters relating to the quality assurance programs of colleges; and
- any matter the Minister refers to HPRAC on the regulation of health professions.[46]

HPRAC is also responsible for monitoring each college's patient relations program and advising the Minister about its effectiveness.[47] HPRAC is also required to report to the Minister, within five years of the *RHPA* coming into force, on the effectiveness of each college's patient relations and quality assurance programs and each college's complaints and discipline procedures for professional misconduct of a sexual nature.[48]

In the consultation document *Weighing the Balance*, HPRAC asked for public comment on its role and responsibilities as outlined in the *RHPA*. Comments from participants centred on the following issues:

- reviews of the *RHPA* and profession-specific Acts;
- timely release of HPRAC reports;
- requests for referrals to HPRAC.

7. Reviews of the *RHPA* and Profession-Specific Acts

Consultation Input

Of the participants who commented on the subject, a majority believed that HPRAC should continue its advisory role. All participants, including the 21 regulatory colleges, recommended that the *RHPA* continue to be reviewed periodically and some specifically stated that HPRAC is the appropriate body to do so.

Some participants believed that legislative reviews should be conducted every three years while others favoured five, seven or 10-year reviews. A majority of participants believed that such reviews would ensure the effectiveness and relevance of the *RHPA* provisions and ensure that the Act's legislative requirements are being appropriately implemented.

HPRAC Analysis

HPRAC is of the view that to ensure accountability of all parties within the regulatory system, regular monitoring and periodic evaluations of specific programs mandated by the *RHPA* are required. Furthermore, regular reviews of each profession-specific Act would ensure that the *RHPA* continues to provide for an efficient and flexible regulatory system.

In 1989, the Health Professions Legislative Review developed criteria for determining whether health professions should be regulated under the *RHPA*. These criteria have been endorsed by the Ministry and HPRAC, and they include:

- whether the profession is relevant to the Minister of Health and Long-Term Care;

[46] Subsection 11 (1) (a) to (e) of the *RHPA*.
[47] Subsection 11 (2) of the *RHPA*.
[48] Subsection 6 (2) (a) and (b) of the *RHPA*.

- whether there exists a substantial risk of harm to the public from the practice of the profession;
- whether practitioners of the profession have the quality of their performance monitored or supervised in another manner;
- whether there might exist a suitable alternative regulatory mechanism;
- whether the profession relies on a distinctive, systematic body of knowledge in assessing, treating or serving its patients/clients;
- whether there are sufficient education requirements for entry to practice;
- whether the profession's leadership has demonstrated an ability to favour the public interest over that of the profession;
- whether it is likely that members of the profession will support and comply with self-regulation; and
- whether there is sufficient membership size and willingness to support the full costs of regulation.

With the changing nature and delivery of health care services in Ontario, and the rapid pace of technological change, there is a need to examine legislation on an ongoing basis to ensure that it meets current needs. For example, there may be a need to include additional controlled acts in the *RHPA* or additional or altered roles for college councils.

Furthermore, the profession-specific Acts should be examined regularly to ensure that they reflect the current nature of a profession's practice and the public need for protection and access to health professional services. This acknowledges the need to examine the knowledge base of a health profession in the face of rapidly expanding knowledge and changing technology and consumer needs.

HPRAC did not undertake a review of each profession-specific Act in the course of conducting its general review of the *RHPA*'s effectiveness. Doing so was simply not feasible as it would involve an in-depth, wide-ranging analysis of a multitude of issues relevant to the public interest and individual professions. Profession-specific reviews would have required a much greater resource commitment on the part of the professions and HPRAC to examine current information/evidence to evaluate risks of harm, changing practices and consumer needs.

HPRAC proposes that any future review of individual professions address the following issues:

- whether there is a continued need for regulation of the profession under the *RHPA* or an alternative mechanism; and
- whether the profession's scope of practice, including authorized controlled acts, needs to be changed.

In addition, HPRAC is of the opinion that the Minister should apply certain criteria, such as those proposed below, when determining priorities for the review of particular professions.

- **Risk of Harm,** i.e. whether advances in technology and/or knowledge and their associated effect on risk of harm to the public warrant changes in the scope of practice of the profession.

- **Governability**, i.e. where there is reason to question the profession's ability to fulfil the requirements of the *RHPA* because of limited membership size or other reasons; e.g. apparent difficulty in implementing statutory programs as demonstrated in HPRAC's program evaluations.
- **Alternative Regulatory Mechanism,** i.e. where a mechanism other than the *RHPA* may be an appropriate means of regulating the activities of a profession or ensuring the quality of its service. Options might include regulating the practitioner's workplace or industry, or assigning regulatory responsibility to another college.

HPRAC is of the view that, in keeping with the above suggested criteria, certain professions may be priorities for review in the context of their profession-specific Acts.

A statutory requirement for systematic, regular reviews of profession-specific Acts would allow the Minister to deal proactively with a broad array of issues in a particular profession. This type of exercise would, in HPRAC's opinion, sustain the effectiveness, efficiency and flexibility of the regulatory system as a whole. A six- or seven-year cycle acknowledges the workload issues associated with reviewing a profession–specific Act and permits three or four such Acts to be reviewed each year.

HPRAC Recommendation(s)

61. That all profession-specific Acts be amended to require reviews every six or seven years. These reviews should be staggered so that they are not all conducted at the same time. HPRAC recommends that a maximum of three or four reviews be conducted per year.

62. That the *RHPA* be amended to include a review of its effectiveness every ten years.

8. Release of HPRAC Reports

Consultation Input

Participants in the consultation indicated some concern about access to HPRAC reports. It was recommended that the *RHPA* provide statutory provisions to indicate the time-frame within which the Minister should respond to advice from HPRAC and release HPRAC reports.

Some colleges were concerned that, although they take part in costly and time-consuming statutory evaluations, they are unable to address concerns about their programs and procedures without access to the evaluation reports.

Overall, a more open and communicative process seemed to be suggested in many submissions, and this is largely related to the sharing of information in reports.

HPRAC Analysis

Access to HPRAC reports has emerged as one of the most problematic issues in the relationships between HPRAC and stakeholders. Colleges and the public see lack of access as undermining

the accountability of HPRAC and the Minister. It is also seen as undermining the independence of and trust in the process used by HPRAC in developing its advice.

The *RHPA* clearly states that HPRAC determines its own processes to review matters.[49] Since the review advice is confidential once given to the Minister, the timing of its release is therefore to be determined by the Minister. Access to HPRAC advisory reports has been successfully challenged through the *Freedom of Information and Protection of Privacy Act*. Therefore, HPRAC contends that it would be prudent for the ministry to develop a clear policy on this matter so as to minimize the potential for unnecessarily strained relations. Greater information sharing and the timely release of HPRAC reports by the ministry would lead to greater trust and accountability and make the review process and advice more transparent.

HPRAC Recommendation(s)

63. That the *RHPA* be amended to require the Minister to release reports from HPRAC within six months of their transmittal to the Minister.

9. Requests for Referral to HPRAC

Consultation Input

A number of those who made submissions expressed concern that some requests for referrals to HPRAC are not being made as requested. These participants stated that delays occur even when such requests are not frivolous or vexatious and are made in good faith.

HPRAC Analysis

Section 12 of the *RHPA* indicates that the Minister is obligated to make referrals to HPRAC if requested and the request is not frivolous or vexatious or not made in good faith. Principles of law suggest that this means the referrals should be timely. Given the backlog of requests for referrals that has existed in the ministry, HPRAC maintains that the referral process should be made more responsive, efficient and transparent.

HPRAC understands that the Minister requires some flexibility in setting priorities and must work with available resources. It also understands that, to make the most appropriate use of these resources, the Minister would want to seek policy advice from HPRAC on issues where follow-up action will be part of the government's agenda.

Some referrals can be expedited by HPRAC while also giving participants an opportunity to provide input and this has been done on several occasions. In cases where the Minister chooses to delay referrals, it is important that requesters be notified of the time period and reasons for the delay. This would uphold the *RHPA* principles of accountability and efficiency and ensure public confidence in the transparency of the referral process.

[49] Subsection 15 (2) of the *RHPA*.

HPRAC Recommendation(s)

64. That the Minister keep requesters informed of the status of their requests for referral to HPRAC.

10. Program Evaluations and Ongoing Performance Monitoring

Consultation input did not comment on program monitoring. There were brief comments that suggested the need for additional statutory evaluation of colleges' programs in the future. The quality assurance and patient relations program evaluations done by Harry Cummings and Associates stressed the importance of more systematic program monitoring and evaluation, and recommended an ongoing role for HPRAC in this regard.

Program evaluations are part of the public accountability of the regulatory system and support the Minister in the statutory responsibility to administer the *RHPA* and the statutory duty to ensure the Act is coordinated in the public interest. Through its statutory responsibility, HPRAC advises the Minister on whether colleges are carrying out their duties appropriately under the *RHPA*. These program evaluations are one vehicle by which the Minister can hold colleges accountable.

However, it is important to recognize that five years is a short time in which to design, implement and demonstrate the effectiveness of new college programs. Outcome evaluation should be structured over a longer time frame, with periodic evaluation based on an ongoing systematic performance monitoring system. Such a system would cover performance indicators that are agreed upon by the colleges, the ministry and HPRAC as being meaningful for the purposes of:

- continuous quality improvement by colleges;
- monitoring and reporting of system-wide performance by HPRAC to the Minister;
- accountability to the Minister and the public; and
- appropriate follow-up and enforcement by the ministry.

Thus, monitoring and evaluation go hand in hand, and both functions must be performed by a body with statutory responsibility for evaluation. HPRAC concludes that the current combined statutory responsibility for monitoring and evaluation of colleges' patient relations programs is a step in the right direction. This combined responsibility should be extended to tracking effectiveness of the other college programs.

Colleges have been concerned that the statutory evaluations have not specified frameworks and performance indicators beforehand. As a result, colleges have not known the criteria by which they would be evaluated, nor have they been able to gear implementation of their programs and data collection in ways that would better inform the evaluations.

The current/recent statutory evaluations clearly indicate the need for continued monitoring, evaluation and reporting on specific college programs. That monitoring, evaluation and reporting

should be based on agreed evaluation frameworks and performance indicators so that colleges can gear their programs and evaluation data-collection efforts accordingly.

The submission of the Federation of Health Regulatory Colleges suggested that sharing the information contained in HPRAC's reports to the Minister would allow colleges to learn from the evaluation findings and make appropriate changes to their programs.

It is clear that the public needs to be better informed about the mandatory programs and activities of the regulatory colleges. Making evaluation reports available to the public would better inform the people of Ontario about the work of colleges and build trust and confidence in the health profession regulatory system – particularly if evaluations and evaluation reports were undertaken by an independent body with a public interest mandate.

Sharing performance and evaluation findings with the public, whether through the ministry and/or the colleges, would indicate to the public that colleges have a public interest mandate and that they, in partnership with government and through an independent body, are striving to improve the regulatory system. The ministry and colleges would be able to highlight the successes and ongoing initiatives of colleges for addressing shortcomings, thereby fostering better relations with the public. This would also play a role in public education about the health professions regulatory system.

Ontario is already considered by other jurisdictions to be a leader in its approach to regulating health professions. The quality assurance evaluation makes it clear that health profession regulatory colleges are already in the forefront with profession-specific quality assurance programs. The evaluation of colleges' complaints and discipline procedures for professional misconduct of a sexual nature makes it clear that there is a need to be more sensitive to the needs of complainants. Their confidence in colleges' handling of misconduct cases is critical to the effectiveness of colleges' complaints and discipline processes. Thus, sharing of evaluation findings reinforces Ontario's leadership in the regulation of health professions.

HPRAC Recommendation(s)

65. **That the *RHPA* assign a statutory responsibility for monitoring and evaluating the specific college programs (for patient relations and quality assurance programs and complaint and discipline procedures) and that this responsibility to evaluate the effectiveness of college complaints and discipline procedures for professional misconduct be expanded to include all types of complaints, and not just sexual abuse complaints.**
66. **That HPRAC continue to be assigned the statutory responsibility for monitoring and evaluation as described above.**
67. **That HPRAC report to the Minister and the public every two years on the program performance indicators developed for the statutory college programs.**

Chapter 11 Summary List of Recommendations

List of Recommendations		Page
Chapter 4 Scopes of Practice		
1.	That periodic/scheduled reviews of profession-specific Acts be used as a means of considering whether to add new authorized acts or remove existing ones, in addition to the current mechanism through which the Minister of Health and Long-Term Care makes referrals to HPRAC of a specific request for expansion of a profession's scope of practice (see also recommendation #61 in Chapter 10 on Roles and Responsibilities, p. 121).	22
2.	That the Minister invite (a) a request for a referral from the College of Dietitians of Ontario on amending the *RHPA* to list the additional controlled act of prescription of therapeutic diets and prescription of enteral and parenteral nutrition, and (b) invite a request for a referral from appropriate psychotherapy groups on amending the *RHPA* to list the additional controlled act of psychotherapy.	22
3.	That the Minister of Health and Long-Term Care refer to HPRAC the question of whether, in consideration of evidence of risk, the simple determination of a need for a hearing aid should be a controlled act, or whether determining the specifications for a hearing aid, based on a hearing test and an assessment of the physical aspects of the ear, should be the controlled act.	29
4.	That the exception for routine activities of living be maintained but the *RHPA* be amended to specify that the exception applies only where the person receiving the care or his/her substitute decision-maker provides informed and explicit consent to the application of the exception.	33
5.	That Section 30(1) of the *RHPA* be amended to add the element of psychological harm.	34
6.	That Section 30(1) of the *RHPA* be amended to remove the word "serious."	34
7.	That Section 30(4) be amended to remove the word "emotional" from the exemption for counselling.	35
8.	That the *RHPA* be amended to prevent someone who is not a regulated health professional from using the words "registered," "regulated," "licensed" or "certified" in the course of providing health care.	36
9.	That the *RHPA* be amended to include a provision that no corporation, association or individuals shall use the word college, alone or in combination	40

List of Recommendations	Page
with other words, in a manner that states or implies that the corporation, association or individual is a college under the *RHPA* unless the corporation, association or individual is a college under the *RHPA* or authorized to use the word college under another enactment.	
Chapter 5 College Governance	
10. That a provision be added in each profession-specific Act to ensure elected professional members have a majority of at least one and no more than two over public appointees. This amendment could be done with reference to specific numbers for elected and appointed members in the profession-specific Acts or as an additional provision indicating that the number of elected members must equal the number of public appointees plus one but not more than two.	46
11. That the Minister take advantage of the proposed legislation changes to consult with colleges about their need to increase or decrease the total number of council members and to add a statutory provision to include council members from professional schools.	46
12. That the *Health Professions Procedural Code (HPPC)* be amended to merge the Complaints Committee functions and Executive Committee screening functions into a single complaints/screening committee with sufficient powers to make definitive dispositions arising from any type of complaint/report received about a member.	50
13. That the *HPPC* be amended to expand the new complaints/screening committee's powers of disposal to expressly include the authority to refer complaints, reports or other information to the Quality Assurance Committee for assessment of competencies and/or development of remediation programs, and the power to issue an interim suspension or practice limitation order.	50
14. That the *HPPC* be amended to merge the functions of the Discipline Committee and the Fitness to Practise Committee to form a single adjudicative committee.	51
15. That the *HPPC* be amended to give jurisdiction over the investigation and referral disposition of incapacity matters to the complaints/screening committee.	51
16. That the *HPPC* be amended to give jurisdiction over the ultimate disposition of incapacity matters to the adjudicative committee instead of the Fitness to Practise Committee.	51

List of Recommendations Page

17. That the *HPPC* be amended to remove the requirement for a Patient Relations Committee but maintain the explicit requirements for the patient relations programs. 51

18. That information be provided to public appointees before their appointment informing them of their role and responsibilities on college councils. 55

19. That the selection of public appointees to college councils be criteria-based and that these criteria include necessary knowledge, abilities and commitment to fulfil the role as a public representative as well as specific knowledge and skills needed by individual colleges. 56

20. That the Ministry of Health and Long-Term Care clearly articulate to colleges that it is the colleges' responsibility to orient and train public members and encourage colleges to ensure public members are oriented to their role. 56

21. That the Minister establish a public member resource committee/task force made up of public appointees and representatives from the Federation of Health Regulatory Colleges and the ministry to: 56
- identify and develop programs and other resources to orient and support public members;
- develop a reliable mechanisms for public members to access and share information;
- develop mechanisms for public members to meet periodically to discuss mutual concerns; and
- explore the development of a national body to coordinate the dissemination of resources and link the public with public interest representatives on governing bodies for professions.

Chapter 6 Complaints and Discipline

22. That the composition of panels of the Complaints Committee as established by s. 25(2) of the *HPPC* continue to require that at least one public appointed member of the college council be on the panel, and that there be a simple majority minus one of public members if a panel sits in large numbers; for example, two public members for a five-member panel, three public members for a seven-member panel. 60

23. That s. 26 of the *HPPC* be amended to allow both complainant and respondent the opportunity to comment in writing, within 30 days of the receipt of the statement, on their respective statements as recorded by the investigator and that those comments be part of the materials presented to the panel of the Complaints Committee before it makes its decisions. 64

List of Recommendations Page

24. That s. 28 of the *HPPC* be amended to require that a panel shall dispose of a complaint within 150 days after the filing of the complaint. 64

25. That the *HPPC* be amended to require that when statutory time frames cannot be met, colleges give notice to complainants and respondents advising them of the reasons for the delay(s) and revised time frame(s) for the disposition of the complaint. 65

26. That s.s. 26 and 36 be amended to require a committee considering a complaint or other report to refer the allegation of professional misconduct to the Discipline Committee where the committee is satisfied that: (1) the allegation is considered serious by the college and/or the panel considering the matter; and (2) the information provided in the complaint or other report, and through subsequent investigation, provides admissible evidence that, if believed by the discipline panel, could result in a finding of professional misconduct. 66

27. That s. 25 of the *HPPC* be amended to provide that the Registrar shall conduct all investigations of complaints and that a panel of the Complaints Committee shall consider all investigations so conducted. 68

28. That the *HPPC* be amended to require that the Complaints Committee or Executive Committee be responsible for monitoring the progress of all complaints and ensure that optimal time lines are met for the disposal of all complaints. 68

29. That s. 23 of the *HPPC* be amended to require that all ADR settlements be subject to approval by a panel of the Complaints Committee and that remediation undertakings that are part of a settlement be published on the Register available to the public. 68

30. That the *HPPC* be amended to specifically provide that ADR may be used only to deal with complaints of the following nature: poor communications; inaccurate or poor documentation and/or record keeping; rude behaviour not indicative of serious practice deficiencies; isolated standards of practice failures not resulting in serious harm; breach of confidentiality; conflicts of interests; and behaviours not indicative of a pattern of practice deficiencies. 68

31. That s. 26 of the *HPPC* be amended to include an express provision allowing a panel of the Complaints Committee to refer the member to the Quality Assurance Committee for assessment of competencies and/or determination of appropriate remediation programs. 69

32. That s. 37 and s. 62 of the *HPPC* be amended to allow either the Executive Committee or the Complaints/Screening Committee to issue an interim 70

List of Recommendations Page

suspension or practice limitation order effective immediately if it is satisfied that, on the balance of probabilities, the conduct of the member would expose his or her patients to harm or injury.

33. That s. 37 and s. 63 require the committee to disclose to the member at the time the order is issued all relevant information and materials relied upon by the committee in making its decision, its reasons for issuing the order, and the member's right to request that the order be reviewed within three days. 70

34. That s. 37 and s. 63 of the *HPPC* be amended to provide the member with the right to request a review of the suspension or practice limitation order by the committee or panel making the order within three days of being given the order, and further provide that, if the committee or panel fails to consider the review within the three days of the request, the order shall lapse. 70

35. That s. 37(3) and s. 62(3) of the *HPPC* be amended to state that an order expires after 12 months or upon disposition by the Discipline Committee, whichever occurs first. 71

36. That s. 29(4) of the *HPPC* be amended to include the college to whom the complaint was made as a party to a review with full rights and obligations. 73

37. That s.29 of the *HPPC* be amended to require that the party appealing a decision of a panel of the Complaints Committee give notice of appeal in which the grounds of appeal and the evidence to be relied upon are clearly stated. 73

38. That s. 33 of the *HPPC* be amended to require disclosure to parties in the review of new documents to be relied upon and those not protected under 32(3) at least 10 days before the review. 73

39. That s. 41 of the *HPPC* be amended to give complainants party status at discipline proceedings, including pre-hearing proceedings to arrive at statement of facts and joint recommendations for undertakings and/or orders, and that complainants be required to indicate their intent to exercise party status within 30 days of receipt of notification of the decision of the panel of the Complaints Committee if proceeding to the Discipline Committee. 76

40. That s. 27 of the *HPPC* be amended to require that the notice given to complainants also contain information about party status, their rights and duties accompanying party status, and their obligation to give notice of their desire to exercise that status within 30 days of receipt of the s. 27 notification. 76

List of Recommendations		Page
41.	The HPPC be amended to state that notwithstanding a complainant's party status, the prosecutorial responsibility rests with the college.	76
42.	That the *HPPC* be amended to require that all ADR settlements be subject to review and approval by the panel of the Discipline Committee hearing the matter and that the settlement be published on the Register available to the public.	78
43.	That the order guidelines recommended for cases of sexual abuse be extended to include all cases of professional misconduct (refer to recommendations 8, 9 and 10 on p. 3 of Appendix B).	79
44.	That s. 71 of the *HPPC* be amended to provide that any order of a discipline panel takes effect immediately despite any appeal.	80
45.	That the *HPPC* be amended to allow a member, who wishes to have the order suspended, the right to bring a motion before a judge of the Divisional Court to suspend the order pending appeal provided that: (1) the order does not relate to incompetence, incapacity or serious sexual abuse as defined in s. 51(5)2 i, ii, iii, or iv; and (2) the member can establish: (a) that his or her appeal has sufficient merit or is otherwise not frivolous; and (b) that the continuation of the order is not necessary in the public interest.	80
Chapter 7 Public Access to Information		
46.	That subsection 36 (1) of the *RHPA* be amended to replace the word "secrecy" with "confidentiality" and to indicate that it is "personal information" that is the subject of confidentiality unless the disclosure of such information is specifically provided for in the *RHPA* (e.g. access to information about a member's professional practice through the Register).	88
47.	That subsection 36 (1) of the *RHPA* be amended to include an additional exception to the confidentiality provisions to allow a college to confirm its actions dealing with a member if it is in the public interest to do so. The HPPC should also specify that the information released in these situations be limited to information necessary to address the public's needs.	88
48.	Subsection 23(3) be amended to require a college to include the following additional information in the publicly accessible part of the Register: (a) Complaints Committee decisions resulting in a referral to the Discipline or Quality Assurance Committee. (b) Information about voluntary undertakings related to remediation and limits	91

List of Recommendations Page

on practice, whether negotiated through ADR, Complaints, Discipline or Quality Assurance Committee processes; the information to remain on the Register for one year or until the undertaking is completed (whichever is longer). This provision should not apply to undertakings related to incapacity issues.

(c) Information about cautions issued to a member, as well as the nature of the member's actions that resulted in the caution; to be removed from the Register after one year following the issuance of the caution if no further cautions have been given to the member.

(d) Information about all reprimands, fines and suspension/practise limitation order issued in connection with disciplinary proceedings and the nature of such reprimands, fines or orders for suspensions or practice limitations. This information should remain on the Register for six years. This removes the discretion from subsection 23 (3) 3. of the Code.

(e) That the Minister direct a process with consumer groups and colleges to explore expanded collection and publication by colleges of information such as information on:

- special areas of practice or competency;
- specialty certificates; and
- malpractice information.

(f) That the Minister require by policy that public information on college Registers be accessible via the Internet by January 2006.

49. That s. 23(1) of the HPPC be amended to require the Register to contain a record of every complaint and report filed with the college and the disposition of the complaint and report. 92

Chapter 8 Quality of Care

50. That the Minister establish a task force to develop a system for reporting and dealing with the health care delivery errors that result in significant adverse patient/client outcomes and prevention of future errors. 102

Chapter 9 Patient Relations

51. That subsection 84(2) of the *RHPA*, which requires colleges to prevent *or* deal with sexual abuse, be amended to require colleges to both prevent *and* deal with sexual abuse. 106

List of Recommendations		Page
52.	That s. 84 of the *HPPC* be amended to require that the program measures must be extended to areas of patient relations beyond those for sexual abuse.	106
Chapter 10 Roles and Responsibilities		
53.	That the *RHPA* be amended to require the Minister in consultation with the colleges to be responsible for designing, implementing and funding ongoing effective education of the public.	112
54.	That the *RHPA* be amended to specify that at a minimum the public education program referred to in recommendation 53 cover the following: (a) which professions are regulated; (b) meaning of regulation – role of college and member requirements for QA, adherence to standards, entry to practice, controlled acts; adherence to standards, entry to practice, controlled acts; (c) role of colleges to protect the public; (d how to make inquiries about a profession or member of a college, and how to make a complaint; (e) the public's right to access information about a health professional.	113
55.	That the *RHPA* be amended to clearly assign to the Minister of Health and Long-Term Care responsibility for enforcement as it would apply to non-members.	115
56.	That the *RHPA* be amended to provide specific mechanisms that give effect to this responsibility, such as the creation of an enforcement capacity within the ministry (or a delegated body) that would handle reported issues, conduct investigations, issue cease and desist orders and initiate prosecutions as needed.	115
57.	That the enforcement capacity/body be provided with adequate resources to effectively enforce the provisions of the *RHPA*.	115
58.	That the Minister, in consultation with colleges, develop service standards that set reasonable timelines for carrying out functions such as processing and approving college regulations, making legislative amendments, and appointing public members.	116
59.	That the Minister ensure those responsible for initiatives related to the establishment of service standards are provided with the resources necessary to achieve the desired outcome.	116

List of Recommendations

		Page
60.	That the Minister, through policy and/or other directives, specify information for planning, monitoring and evaluation purposes that colleges are to provide in their annual and other specified reports.	117
61.	That all profession-specific Acts be amended to require reviews every six or seven years. These reviews should be staggered so that they are not all conducted at the same time. HPRAC recommends that a maximum of three or four reviews be conducted per year.	121
62.	That the *RHPA* be amended to include a review of its effectiveness every ten years.	121
63.	That the *RHPA* be amended to require the Minister to release reports from HPRAC within six months of their transmittal to the Minister.	122
64.	That the Minister keep requesters informed of the status of their requests for referral to HPRAC.	123
65.	That the *RHPA* assign a statutory responsibility for monitoring and evaluating the specific college programs (for patient relations and quality assurance programs and complaint and discipline procedures) and that this responsibility to evaluate the effectiveness of college complaints and discipline procedures for professional misconduct be expanded to include all types of complaints, and not just sexual abuse complaints.	124
66.	That HPRAC continue to be assigned the statutory responsibility for monitoring and evaluation as described above.	124
67.	That HPRAC report to the Minister and the public every two years on the program performance indicators developed for the statutory college programs.	124

APPENDICES

APPENDIX A: HPRAC'S RECOMMENDATIONS TO THE MINISTER ON COLLEGES' QUALITY ASSURANCE PROGRAMS

Current Status and Innovative Approaches

1. That the Minister write to all colleges, with the exception of the College of Denturists, to commend them on developing and implementing quality assurance programs within a short period of time.

2. That the Minister require the College of Denturists to provide to the ministry by December 31, 2000, information on its quality assurance programs so that the ministry can assess those programs against the elements of the model quality assurance program and provide direction for further program development and implementation.

3. That the Minister host a conference collaboratively with colleges to share innovative experiences on quality assurance activities.

Developing Program Components

4. That the Minister require all colleges to fully implement all components of the model quality assurance program by December 2001.

5. That the ministry provide detailed guidelines for the colleges on the elements and methodology of practice assessment which is a mandatory component of their quality assurance programs to ensure consistency across colleges while allowing each college sufficient flexibility to accommodate the different practice settings of its members.

College Powers

6. That existing regulatory provisions be fully utilized by colleges to enforce compliance by members with quality assurance program requirements and remediation orders.

Capacity-building and Evaluation

7. That the Minister require all colleges to develop and implement overall evaluation plans for their quality assurance programs by December 2002.

8. That the Minister share HCA's report and recommendations with colleges and prompt them to explore opportunities for coordination and partnering in implementing HCA's recommendations with respect to enhancing their evaluation capacity.

9. That colleges, the ministry and HPRAC collaborate in instituting a performance monitoring system based on a consistent set of core and college-specific indicators for colleges' quality assurance programs, to facilitate future evaluations.

10. That the RHPA be amended to give HPRAC statutory responsibility for ongoing monitoring of colleges' quality assurance programs and for conducting periodic evaluations of the effectiveness of these programs.

APPENDIX B: HPRAC'S RECOMMENDATIONS FOR COMPLAINTS AND DISCIPLINE FOR PROFESSIONAL MISCONDUCT OF A SEXUAL NATURE

The following are recommendations made by HPRAC to the Minister of Health and Long-Term Care regarding sexual abuse of patients/clients by regulated health professionals.

PREVENTION-PRIMARY

To help prevent sexual abuse of patients/clients, HPRAC recommends that:

1. **The Ministry of Health and Long-Term Care undertake public education, including through print, television radio media and internet, to inform the Ontario public about its rights and remedies under the RHPA and the impropriety of health professionals having sexual contact with their patients/clients.**

2. **Section 84(2) of the Health Professions Procedural Code (HPPC), which requires colleges to prevent deal with sexual abuse, be amended to require colleges to both prevent and deal with sexual abuse.**

PREVENTION-DETERRENCE

Mandatory Reports

To improve the preventive value of mandatory reports and deter sexual abuse, while maintaining the patient's right to privacy, HPRAC recommends that:

3. **The HPPC be amended as follows:**

   - **to require colleges and members dealing with mandatory reports to actively encourage patients to consent to their names being included in mandatory reports;**

   - **Subsection 85.1 (3) of the HPPC be amended to replace "best efforts" with the requirement that the patient or, if the patient is incapable, the patient's representative, be notified by the health professional filing the mandatory report of the obligation that the professional has to file the report;**

- **Section 85.3 of the HPPC be amended to require that the health professional seek informed consent from the patient/client or their representative to name the patient/client;**

- **Section 85.3 of the HPPC be amended to require the health professional to give information to the patient or their representative, if the patient is incapacitated, about the support services referred to in Recommendation 11 so that the patient may obtain information and advice on giving consent and on being a witness in the investigation and disciplinary process;**

- **Subsection 85.3(3) be amended to allow a patient's name to be added to a mandatory report after that report has been filed if consent has subsequently been obtained.**

To clarify the expectation for Colleges dealing with mandatory reports, it is recommended that:

4. The HPPC be amended as follows:

- **Section 75 of the HPPC be amended to require the vollege Registrar, where the Registrar believes on reasonable and probable grounds that a member has committed sexual abuse of a patient, to appoint an investigator upon receiving a mandatory report.**

- **Section 79 of the HPPC be amended to require that, following any inquiry or investigation under s. 75, a report be sent by the Registrar to the Executive Committee or panel considering complaints.**

Disclosure of Settlements and Decisions

To deter sexual abuse and support informed choice of health professionals by patients, it is recommended that:

5. Subsections 23(1) and (3) of the HPPC be amended to require the publication on, and public access to, the Register, and in a college report, of cautions and all Complaints Committee decisions respecting a member that result in a referral to Discipline, referral to Quality Assurance, or remediation undertaking. In addition, s. 27 of the HPPC be amended to require that this information be published in a college report.

6. **The HPPC be amended to require colleges to record on the public register and in a college report the names of members who resign or do not renew their certificate following a complaint or mandatory report about sexual abuse and to include the nature of the allegation that was being investigated at the time of the resignation or lapse of membership in the college.**

7. **Subsection 23(3) 3.1 of the HPPC be amended to remove a college's discretion and require that findings of guilt with respect to behaviour or remarks of a sexual nature by a health professional towards a patient/client be put on the Register and be available to the public.**

Order Guidelines

To promote flexible but consistent and transparent discipline decisions, it is recommended that:

8. **Subsections 51(5) and 72(3) of the HPPC be amended to maintain automatic revocation of a member's certificate of registration for cases of serious sexual abuse (as defined in s. 51(5)2 of the HPPC) for a period of time left to the discretion of the Discipline panel.**

9. **Section 51 of the HPPC be amended to require the Discipline panel to consider the severity and circumstances of the misconduct in determining the length of revocation, with particular attention to the following factors to be specified in the HPPC:**

   - **the severity of abuse;**
   - **the need for proportionality, the disposition must be proportionate to the gravity of the professional misconduct and the degree of responsibility of the respondent;**
   - **the need to separate the respondent from the profession to protect the public from harm;**
   - **the need to denounce the unprofessional conduct;**
   - **the impact on the victim(s);**
   - **the remorse of the respondent;**
   - **specific and general deterrence;**
   - **potential for rehabilitation; and**
   - **any other factor the panel considers appropriate in the circumstances.**

10. **With respect to re-application, it is recommended that s. 72 of the HPPC, which deals with reinstatement, be amended to provide that, in cases of re-application after a member's certificate of registration has been revoked due to professional misconduct of a sexual nature, the Registration Committee consider the following factors in deciding whether to re-admit the member:**

- **public safety;**
- **rehabilitation of the member;**
- **practice restrictions, including supervisory requirements; and**
- **appropriateness of a probationary period.**

TREATING PEOPLE WITH SENSITIVITY AND RESPECT

Support Services

To acknowledge the special dynamics of sexual abuse and to support patients/clients who may have been sexually abused, it is recommended that:

11. **The Ministry of Health and Long-Term Care establish a program to provide support services to patients/clients reporting sexual abuse by health professionals and that this service have the following functions:**

    - **provide information about making a complaint to a college or giving consent to be named in a mandatory report;**
    - **provide information and other non-therapy supports to complainants and subjects of mandatory reports throughout the college complaints, resolution and disciplinary processes;**
    - **assist patients in making application for funding for therapy and counselling;**
    - **assist patients in obtaining treatment by another member of the college in cases where continued care by the subject of a mandatory report or complaint is no longer appropriate or desired by the patient.**

12. **The Ministry of Health and Long-Term Care maintain a roster of service providers available in Ontario to provide support to patients/clients reporting sexual abuse by members and that these providers be selected based on published criteria and that the criteria stipulate that a member of a college cannot provide support services to a patient who has a complaint of sexual abuse against a member of that college.**

13. **The ministry design the funding of the support service program to include a charge-back to colleges based on a system that fairly charges specific colleges according to the volume and intensity of services provided to people who were reportedly abused by their members.**
14. **The RHPA be amended to require colleges to inform patients/clients who are reporting sexual abuse by a member of the college of the support service and require colleges to fund the support services as directed by the Minister.**

Funding for Therapy and Counselling

To expand current provisions in the RHPA to improve access, timeliness, sensitivity and appropriateness of therapy for sexual abuse, it is recommended that:

15. Alternative eligibility criteria for funding for therapy and counselling be stated in legislation by amending the HPPC as follows:

Subsection 85.7(4) of the HPPC be amended by revoking subsection 85.7(4)(b) and in its place enacting the following "alternative criteria for eligibility":

(i) there is an admission made by a member in a statement to the college or in an agreement with the college that he or she sexually abused the person while the person was a patient/client of the member;

(ii) a member has been convicted under the Criminal Code (Canada) of sexually assaulting the person while the person was a patient/client of the member;

(iii) there is a finding made by a panel of the Discipline Committee on or after December 31, 1993, that the person was sexually abused by a member before or after December 31, 1993, while the person was a patient/client of the member;

(iv) there is a statement, contained in the written reasons of a committee of the college given after a hearing, that the person, while a patient/client, was sexually abused by a member; or,

(v) there is sufficient evidence presented to the Patient Relations Committee to support a reasonable belief that the person, while a patient/client, was sexually abused by a member.

(vi) For the purposes of clause (v), and without limiting the generality of that clause, the following kinds of evidence may support a reasonable belief that a person, while a patient/client, was sexually abused by a member:

- **Evidence that a notice of hearing was issued by the college and containing allegations that the person, while a patient/client, was sexually abused by a member who died before a hearing was held;**

- **Evidence of reports made with respect to the member under subsection 85.1 (1) of the Health Professions Procedural Code (HPPC); or**

- **Evidence that corroborates the person's allegations of sexual abuse.**

16. **That s. 85.7(9) of the HPPC be amended to expand the provision of funds to patients/clients for the cost of medications, child care, and reasonable travel/accommodation expenses associated with accessing therapy related to sexual abuse.**

17. **That s. 85.7 of the HPPC be amended to include provisions for funding for therapy that specify funding be retroactive so that the complainant is compensated for therapy received during the period prior to the hearing for counselling arising from sexual abuse by a member.**

18. **That s. 85.7 of the HPPC be amended to prevent the disclosure of a complainant's information respecting their application for funding for therapy and counselling to the member named in the application.**

PROCEDURAL FAIRNESS

Standard for Referral to Discipline

To clarify when an allegation of sexual abuse should be referred to Discipline Committee, it is recommended that:

19. **Sections 26 and 36 of the HPPC be amended to require a panel of the Complaints Committee considering a complaint, or the Executive Committee considering a report, about sexual abuse to refer the allegation(s) of professional misconduct to the Discipline Committee where the committee panel is satisfied that: (1) the allegation is serious; and (2) that the information contained in the complaint or report, and through subsequent investigation provides admissible evidence which, if believed by a panel of the Discipline Committee, could result in a finding of professional misconduct.**

    "Serious" is to be defined herein as being: (1) sexual abuse as defined in s. 51(5)2; (2) repeat occurrences of sexual abuse as defined in s. 1(3)(c); or (3) conduct or actions which, in the opinion of the college or panel, are "serious".

Complaints Process

To clarify the responsibility and accountability for the investigation of complaints and mandatory reports, including those related to sexual abuse, it is recommended that:

20. Section 25 of the HPPC be amended to state that the Registrar shall investigate a complaint or mandatory report instead of a panel of the Complaints Committee doing the investigation.

21. The HPPC be amended to require the Complaints Committee or Executive Committee to monitor the progress (including withdrawal) of all complaints and ensure optimal timeliness for the disposition of the complaint.

22. Section 26 of the HPPC be amended so that the complainant and respondent each be given an opportunity to comment upon their respective statements as recorded by a college investigator which forms part of the investigator's report to the panel within 15 days of receiving their statements from the college, and that those comments be included with the materials submitted to a panel of the Complaints Committee prior to the panel's decision.

23. The time frame for disposal of the complaint as provided in s. 28 of the HPPC be extended to 150 days so as to allow time for the complainant and respondent to comment on their own respective statements as prepared by the investigator.

24. Section 28 of the HPPC be amended to require that colleges communicate to complainants when there is a delay in disposing their complaint, advising them as to the reasons for any delay, and providing a revised time frame for the disposition of their complaint.

Alternate Dispute Resolution (ADR)

To clarify when it is appropriate to permit resolution of a report or complaint of sexual abuse outside of a discipline hearing, it is recommended that:

25. The Minister direct that colleges never use ADR involving a person who was allegedly the subject of sexual abuse by a member for cases of sexual abuse as defined in s. 51 (5) 2 of the HPPC.

26. The HPPC be amended to require that all settlements or undertakings reached with members as a result of a complaint or mandatory report alleging sexual abuse be subject to approval by a committee or panel.

Party Status

In order to encourage complainants to come forward and to ensure full participation and disclosure of information in a discipline proceeding, it is recommended that:

27. Section 41 of the HPPC be amended to give complainants, in cases of sexual abuse, party status at discipline proceedings including pre-hearing proceedings to arrive at statements of fact and joint recommendations for undertakings and/or dispositions and that complainants be required to indicate their intent to exercise party status within 30 days of receipt of notification of the decision of the panel of the Complaints Committee to refer the matter to the Discipline Committee.

To protect the mandate of the college and clarify roles, it is recommended that:

28. The HPPC be amended to state that notwithstanding a complainant's party status, the prosecutorial responsibility and discretion rests with the college.

Evidence at Disciplinary Hearings

To ensure that complainants who are witnesses in cases of alleged professional misconduct of a sexual nature are protected and treated with sensitivity and respect in a disciplinary proceeding in like manner as protections are offered under the Ontario Evidence Act, R.S.O. 1990, c. E.22, it is recommended that:

29. The HPPC be amended to include the following sections respecting the evidence of complainants in cases of sexual abuse:

Videotape Testimony

1(1) A videotape of the testimony of a witness who is a complainant in a case of sexual abuse that satisfies the conditions set out in subsection (2) may be admitted in evidence, if the panel of the Discipline Committee hearing the allegation is of the opinion that this is likely to help the witness give complete and accurate testimony or that it is in the best interests of the witness.

(2) The panel and the lawyers of the parties to the proceeding shall be present when the testimony is given, and the lawyers shall be given an opportunity to examine the witness in the same way as if he or she were testifying in the courtroom.

(3) Subsection 2 (1) and section 3 apply with necessary modifications when testimony is being videotaped.

(4) If a videotape is admitted under subsection (1), the witness need not attend or testify and shall not be summoned to testify.

(5) However, in exceptional circumstances, the panel may require the witness to attend and testify even though a videotape of his or her testimony has been admitted in evidence.

(6) With the leave of the panel, a videotape of an interview with a complainant of sexual abuse may be admitted in evidence if the person, while testifying, adopts the contents of the videotape.

(7) Subsection (6) is in addition to any rule of law under which a videotape may be admitted in evidence.

Screen

2(1) A witness who is a complainant in a case of sexual abuse may testify behind a screen or similar device that allows the witness not to see an adverse party, if the panel is of the opinion that this is likely to help the witness give complete and accurate testimony or that it is in the best interests of the witness, and if the condition set out in subsection (4) is satisfied.

(2) The panel may order that closed-circuit television be used instead of a screen or similar device if the panel is of the opinion that,

> **(a) a screen or similar device is insufficient to allow the witness to give complete and accurate testimony; or**
>
> **(b) the best interests of the witness require the use of closed-circuit television.**

(3) If the panel makes an order under subsection (2), the witness shall testify outside the committee room and his or her testimony shall be shown in the committee room by means of closed-circuit television.

(4) When a screen or similar device or closed-circuit television is used, the panel, the panel's legal counsel, and the parties to the proceeding and their lawyers shall be able to see and hear the witness testify.

Support Person

3.(1) During the testimony of a witness who is a complainant in a case of sexual abuse, a support person chosen by the witness may accompany him or her.

(2) If the panel determines that the support person chosen by the witness is not appropriate for any reason, the witness is entitled to choose another support person.

(3) The following are examples of reasons on the basis of which the panel may determine that the support person chosen by a witness is not appropriate:

1. The panel is of the opinion that the support person may attempt to influence the testimony of the witness.

2. The support person behaves in a disruptive manner.

3. The support person is also a witness in the proceeding.

Cross-examination

4.(1) The panel shall prohibit personal cross-examination of a witness who is a complainant in a case of sexual abuse by an adverse party if the panel is of the opinion that such a cross-examination,

(a) would be likely to affect adversely the ability of the witness to give evidence; or

(b) would not be in the best interests of the witness.

(2) If the panel prohibits personal cross-examination by the adverse party, the cross-examination may be conducted in some other appropriate way (for example, by means of questions written by the adverse party and read to the witness by the panel).

INTER-SECTORAL COORDINATION

To increase public access and use of information about health professionals who have been or are the subject of a college proceeding about sexual abuse, it is recommended that:

30. A publicly accessible central register be established for all regulated health professions in Ontario to record all registered findings and dispositions for professional misconduct of a sexual nature against regulated health professionals and that the central register be maintained under the auspices of the Minister of Health and Long-Term Care.

31. The Minister undertake discussions with her federal, provincial and territorial counterparts to establish a national register.

32. The Minister request the Attorney General to require Crown Attorneys to notify the Registrar of the relevant regulatory college if a member of a regulated health profession is convicted for a sexual crime against a patient/client. It is recommended that, in the event a central and/or national register is established, pursuant to Recommendation 30 above, the Attorney

General require Crown Attorneys to notify the keeper of the register who, in turn, would notify the appropriate college Registrar of the conviction.

33. The Minister request the Solicitor General to require all investigating police officers to notify the Registrar of the relevant regulatory college if a member of a regulated health profession is charged with a sexual crime against a patient/client. It is recommended that, in the event a central and/or national register is established, the Solicitor General require police officers to notify the keeper of the register who, in turn, would notify the appropriate college Registrar of the charge.

34. The Rules of Civil Procedure which govern civil proceedings be amended to provide for automatic notification to the relevant regulatory college with respect to a Statement of Claim being issued against a member of that college for damages due to incidents alleging sexual abuse. It is also recommended that the relevant regulatory college be notified of the discontinuance of any action or be given Notification of Outcome at the judicial conclusion of the proceedings.

35. In cases of reinstatement, colleges notify the Central and National Register of the application and conditions, if any, of the reinstatement.

36. On receipt of an application for registration, colleges be required to obtain information about previous convictions and charges of sexual abuse and allegations of professional misconduct related to sexual abuse from all jurisdictions where the person has practised as a health care provider.

MONITORING, EVALUATION AND REPORTING

To ensure continued accountability and optimal effectiveness, it is recommended that

37. HPRAC have a continued statutory mandate to evaluate college programs related to the prevention and handling of sexual abuse of patients

38. HPRAC work cooperatively with colleges and the ministry to develop a comprehensive framework for ongoing monitoring and periodic effectiveness evaluation of colleges' complaints and discipline processes related to sexual abuse and that this framework include:

- **Process and outcome indicators;**
- **Measurement strategies;**
- **Annual reporting requirements; and**
- **Frequency of evaluation cycle.**

39. The Minister direct that, starting 2001/2002, colleges report the following information in their annual reports and that further reporting requirements to the Minister be made following the development of the monitoring and evaluation framework:

- **Number of complaints and mandatory reports about sexual abuse received by the college by category of sexual abuse, (i.e. HPPC s. 1a, b or c);**
- **Aggregate information about the disposition of complaints and mandatory reports including any resolutions of complaints/reports that have not been referred to discipline hearing;**
- **Number of complaints that were handled within 150 days, reasons for delay in handling those that were not handled within 150 days; and**
- **Aggregate information about decisions and penalties issued by discipline panels by type of sexual abuse.**

40. The Minister require the colleges of Denturists, Optometrists and Opticians to provide information about the indications of effectiveness of their activities related to the handling of and readiness to handle complaints and discipline proceedings for sexual abuse, and direct appropriate action to ensure their effectiveness.

APPENDIX C: MAJOR PROFESSION-SPECIFIC ISSUES RELATED TO LEGISLATION AND REGULATION

Health Profession Association or College	Issue
College of Audiologists and Speech-Language Pathologists of Ontario	• hearing assessment be included as a controlled act when the assessment is being performed for the purpose of prescribing a hearing aid • amend controlled act #10 to amend the controlled act regarding prescribing a hearing aid to include selecting, verifying or validating a hearing aid for a hearing impaired person
Ontario Association of Speech-Language Pathologists and Audiologists	• audiologists be authorized to diagnose audiological disorders • speech-language pathologists be authorized to diagnose communication and oral-pharyngeal swallowing disorders • college members with advanced clinical degrees i.e. Ph.D., AuD. be allowed to use the title "doctor" • clarify the controlled acts of prescribing a hearing aid by stating that only an audiologist can specify ear(s), make, model and acoustic parameters • amend scope of practice statement to include diagnosis, diagnosis and treatment of oral-pharyngeal swallowing disorders and focus on "communication" rather than "language" functions
Ontario Society of Chiropodists	• chiropodists to be authorized to communicate a chiropody specific diagnosis
College of Chiropractors of Ontario	• access to laboratory services to support chiropractic diagnosis
Ontario Chiropractic Association	• the Ministry set up a cross-professional task force to develop minimum standards of education for those health professions authorized to perform spinal manipulation
Chiropractic Awareness Council	• only members of the College of Chiropractors of Ontario be authorized to perform spinal manipulation
Canadian Memorial Chiropractic College	• members be authorized to order laboratory diagnostic tests • a consistency of standards for spinal manipulation be developed
College of Dental Hygienists of Ontario	• dental hygienists be authorized to administer a

Health Profession Association or College	Issue
College of Dental Hygienists of Ontario continued	substance by injection or inhalation • dental hygienists be authorized to order x-rays
Ontario Dental Hygienists' Association	• an agreement as to the definition or direction of an order from a dentist prior to dental hygienists performance of their authorized acts of scaling and root planing be realized with the Royal College of Dental Surgeons Of Ontario • dental hygienists be authorized to: 1) communicate a dental hygiene diagnosis 2) administer a substance by injection or inhalation
College of Dental Technologists of Ontario	• coordination of the supervision of laboratory practice with the Royal College of Dental Surgeons of Ontario to ensure consistent standards
Association of Dental Technologists of Ontario	• a definition of "supervision" by a member of the college include supervision of all technical aspects of the design, construction, repair or alteration of a dental prosthetic, restorative or orthodontic device • expanded scope of practice to include inter-oral procedures
Ontario Dental Association	• the use of lasers and "applying" drugs be controlled acts
Ontario Society of Oral & Maxillofacial Surgeons	• request for the control act of putting: - an instrument, hand or fingers beyond the external ear canal, the point in the nasal passages where they normally narrow, the larynx, the opening of the urethira, the anal verge, and into an artificial opening into the body. • communicating a diagnosis that be identified from i. the patient health history ii. the findings of a comprehensive health examination, or iii. the results of any laboratory tests other than tests and investigations
College of Denturists of Ontario	• authorize denturists to order radiographs (x-rays)
Denturists Association of Ontario	• authorize denturists to order radiographs (x-rays)

Health Profession Association or College	Issue
Denturists Association of Ontario continued	• fitting of anti-snoring devices be a controled act authorized to denturists
College of Dietitians	• add prescription of therapeutic diets to the list of controlled acts and authorize dietitians to perform this controlled act • add prescription of enteral and parenteral nutrition to the list of controlled acts and authorize dietitians to perform this act • add exemptions to controlled acts to allow dietitians to: obtain a blood sample by finger pricking; distribute non-prescription prenatal vitamins and mineral supplements to pregnant clients enrolled in prenatal nutrition programs; distribute free samples of lactase to patients who are lactose intolerant and alpha galactosidase to patients who have difficulty digesting complex carbohydrates
Ontario Society of Medical Technologists	• new controlled act for medical laboratory quality control procedures • add electrocardiogram to the list of forms of energy that constitute a controlled act
College of Medical Laboratory Technologists of Ontario	• provide the College with more authority over the place of practice similar to that for pharmacies • align the *Laboratory and Specimen Collection Centre Licensing Act* with the *Medical Laboratory Technology Act* to provide for greater sharing of information regarding member practice settings
College of Nurses of Ontario	• nurses be authorized to: - communicate a diagnosis - dispense a medication, and - apply a form of energy (defibrillation, electrocoagulation and transcutaneous cardiac pacing) • remove title "Graduate Nurse" from the *Nursing Act*
Registered Nurses Association of Ontario	• registered nurses who possess doctoral degrees be allowed to use the title "doctor" • greater emphasis on prevention in the nursing scope of practice
Registered Practical Nurses Association of Ontario	• the *Nursing Act* be amended to reflect equal representation of RPNs and RNs on the CNO

Health Profession Association or College	Issue
Registered Practical Nurses Association of Ontario continued	college council
Ontario Society of Occupational Therapists	• splinting be included as a controlled act
College of Opticians of Ontario	• the college be authorized to regulate the optical dispensing environment in which members practice in a way similar to pharmacies
Ontario Opticians Association	• conflict of interest guidelines stipulate a prescriber must issue a written prescription to a patient at the time of the examination • include dispensing artificial eyes and hearing aids as controlled acts
Opticians Association of Canada	• opticians be authorized to "prescribe" using new computer technology
Ontario Osteopathic Association	• osteopaths have an Ontario governing body to recognize their qualifications and register them based on these qualifications • the title "osteopath" be protected
Ontario College of Pharmacists	• pharmacists who have earned the academic degree "doctor" be permitted to use this title as a vocational designation
Ontario Pharmacists Association	• pharmacists be authorized to prescribe under limited, specific protocols and perform certain diagnostic tests
College of Physiotherapists of Ontario	• physiotherapists be authorized to communicate a diagnosis within the scope of practice of physiotherapists
Ontario Physiotherapy Association	• physiotherapists be authorized the controlled acts of putting an instrument, hand and or finger beyond the anal verge and performing a procedure below the dermis
College of Psychologists of Ontario	• the *Psychology Act* be amended to allow psychological associates to communicate a diagnosis: 1) under supervision 2) autonomously if the psychological associate has upgraded with the necessary skills • hypnosis and psychotherapy be a controlled acts • amend college council composition by adding 2 professional seats on council, 1 for psycholoigical associates and one for

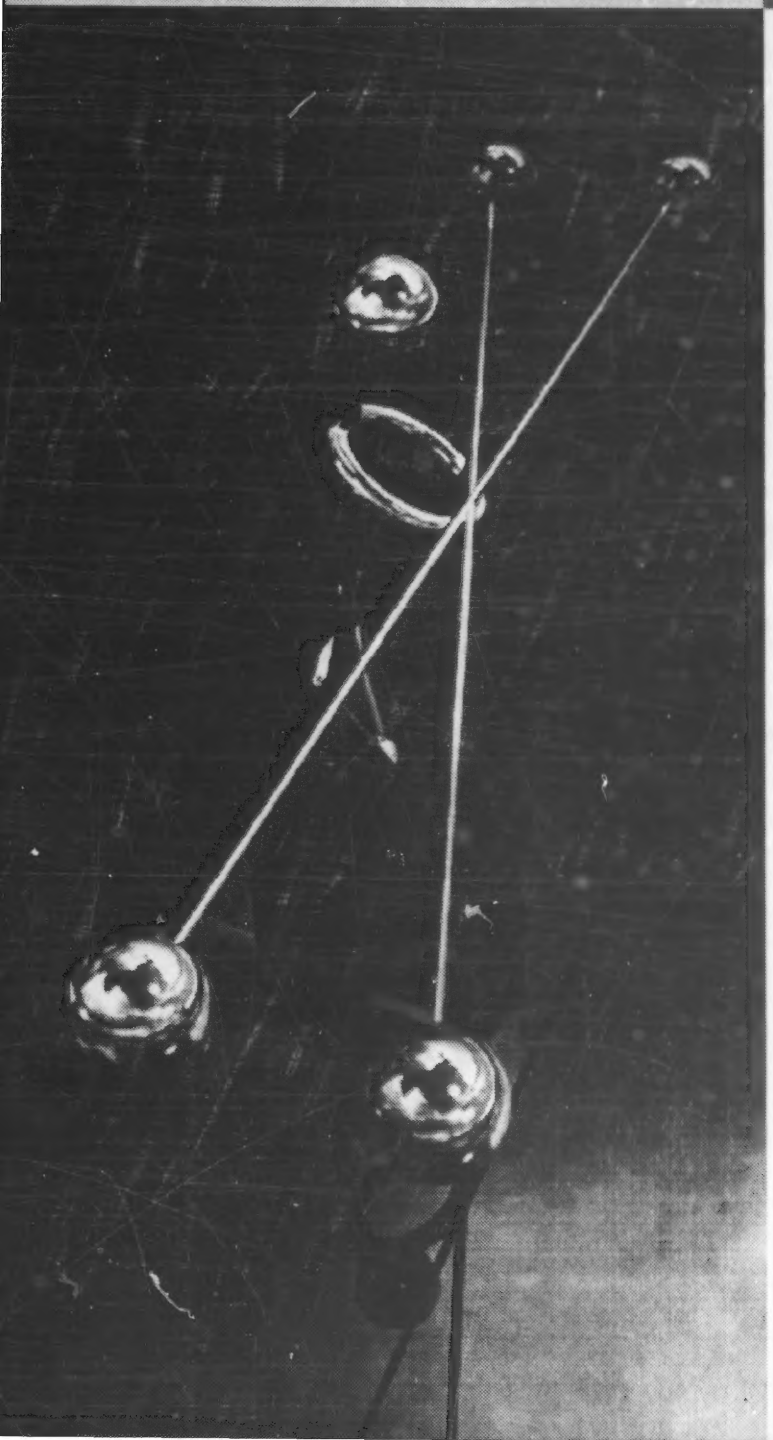
Health Profession Association or College	Issue
College of Psychologists of Ontario continued	psychologists, and, add one public member • specify in regulation a doctorial level education, training and experience for authority to perform the psychology controlled acts
Ontario Psychological Association	request authority to prescribe drugs the list of controlled acts include: • use of psychological tests • hypnosis • psychotherapy – distinguished from counselling • the *Psychology Act* distinguish between the scopes of practice of psychologists and psychological associates
Canadian Academy of Psychologists in Disability Assessment	• psychological associates be authorized to communicate a diagnosis • the *Psychology Act* be amended to differentiate between the scope of practices of psychologists and psychological associates
Ontario Association of Psychological Associates	• the title "psychological associate" be changed to a professional label readily understood by the public • no changes be made to the *Psychology Act* with respect to scope of practice for psychological associates • psychological associates be ensured voting representation on college council and a guarantee of adequate representation of both classes of members on every college committee
College of Respiratory Therapists of Ontario	• lack of clarity over whether members of respiratory therapy associations can use the designation "RRT" (registered respiratory therapist) without being college members • a nurse or physician be permitted to supervise a student respiratory therapist
Respiratory Therapy Society of Ontario*	• add a new controlled act of applying or ordering the application of energy in the form of medical gases under high pressure in mechanical ventilation • having two designations RRT (Registered Respiratory Therapists) and RRCP (Registered Respiratory Care Practitioner) is

* Psychology and respiratory therapy issues were also raised in submissions made by individual health professionals

Health Profession Association or College	Issue
Respiratory Therapy Society of Ontario continued	confusing for the public • the Core-Competency Evaluation process implemented by the College is actually a recertification exam not legally mandated by the RHPA**

** The Ontario Divisional Court rejected this assertion by the Society and has expressly upheld the college's jurisdiction with respect to the Core Competency Exam for quality assurance.

assurance judgements effectiveness efficiency flexibility fairness balance **effectiveness** consider purpose protect principles enhance accountability evolve respect rights fairness confidence ***efficiency*** cooperation treatment rights balance recognize powers regulated protect maintain promote quality ensure **flexibility** respect practice processes respond consumers individual develop obtain question rights barriers ensure **fairness** costs identify enable determine facilitate efficient resource adequate checks and balances compliance discipline processes programs



Adjusting the Balance

A Review of the Regulated Health Professions Act

Health Professions Regulatory Advisory Council

Ontario

ERRATA

Please note, to encourage increased participation in the review process, the following changes have been made:

1. **We prefer that you provide input by making written submissions based on questions in "Weighing the Balance" and send it in with a signed Release Form provided in the back of that document. Alternatively, however, you may just write to us about your personal views or experiences.**

2. **The deadline for providing input has been extended from October 29, 1999 to December 31, 1999.**

A Letter from the Chair of the Health Professions Regulatory Advisory Council

When the *Regulated Health Professions Act* (RHPA) came into effect on December 31st, 1993, it was widely regarded as "ground-breaking" legislation. Our task, some five years later, as a result of a ministerial refferal, is to determine whether it has fulfilled its key objectives and provided a regulatory system that is—and will continue to be—effective, efficient, flexible and fair.

Undertaking a thorough review of the RHPA's effectiveness and impact is an ambitious task that cannot be completed without the assistance, advice and input of those who regulate, provide and receive health care services in Ontario. This includes individual patients/clients, advocacy groups, academic institutions, individual health professionals, associations of regulated and unregulated health professions, regulatory Colleges and members of the general public.

This publication is meant to provide you with a general understanding of *Regulated Health Professions Act* provisions concerning protection from harm, quality of care, accountability, efficiency, flexibility and fairness. Key questions concerning the effectiveness and impact of these provisions are listed in each section. Supplementary and more detailed questions, which may help you to frame your responses, are also included.

Although focus groups, public hearings and other methods will also be used to obtain feedback and frame recommendations for the Minister of Health's consideration, I cannot over-emphasize the importance of receiving your comments concerning any or all of these questions.

The process for making a submission is described in Appendix 4 of this publication and I urge you to read it carefully before doing so. Please note that all submissions must be received by October 29th, 1999 and that we are unable to accept submissions that are not accompanied by a signed copy of the Release Form that appears on the last page of the publication.

In the meantime, I wish to thank you, in advance, for your assistance and look forward to receiving your views on the significant issues raised in this publication.

Rob Alder, M.Med.Sc., Ph.D.

Table of Contents

Section	Page Number
Introduction	1
An overview of the Regulated Health Professions Act	3
Section I — Protection From Harm	7
Section II — Quality of Care	15
Section III — Accountability	20
Section IV — Efficiency	26
Section V — Flexibility	30
Section VI — Fairness	35
Appendix 1 — Review Referral Terms of Reference	41
Appendix 2 — Health Regulatory Colleges	44
Appendix 3 — Controlled Acts	45
Appendix 4 — How to Make a Submission	46
Submission Consent and Release Form	49

Introduction

The *Regulated Health Professions Act* (RHPA), which came into force on December 31, 1993, provides a common framework for the regulation of those who work in Ontario's 23 regulated health professions. While the RHPA provides a common framework, there is in addition a series of profession-specific acts that specify such things as the scope of practice of each profession.

Under the provisions of the RHPA, the Minister of Health may refer any matter regarding the regulation of health professions to the *Health Professions Regulatory Advisory Council* (Advisory Council) for its review and recommendations. Under this authority, the Minister has asked the Advisory Council to review the effectiveness and impact of the RHPA and profession-specific Acts. This referral is called the Review Referral (Review).

The Review will determine whether the system's effectiveness and impacts—efficiency, flexibility and fairness—are appropriately balanced in relation to each other. The notion of balance is reflected in the title of this document—***Weighing the Balance.***

The Advisory Council's *Terms of Reference* for this Review Referral are detailed in Appendix 1.

Scope of the Review

As mentioned, the Advisory Council's Review will determine whether the RHPA has generated a regulatory system that is effective, efficient, flexible and fair.

The Act's ***effectiveness*** will be evaluated by determining the extent to which three of its key objectives have been met—protecting the public from harm, providing high quality care and making health professionals accountable for their actions.

The Review will assess the regulatory system's ***efficiency*** by determining whether the time and resources required to achieve the RHPA's purposes and principles are reasonable. It will also determine whether the administrative burden of regulation could be reduced without lessening the system's effectiveness, flexibility or fairness.

As the health care system evolves, it is essential that the RHPA remain flexible enough to address changes in the roles and utilization of health professionals. ***Flexibility*** will be evaluated by determining whether the regulatory system has been able to respond to emerging issues in a timely manner.

The Review will determine whether the regulatory system has promoted ***fairness*** by assessing the extent to which it has achieved the following objectives:

- respect for the rights and interests of patients/clients and health care professionals;
- equitable treatment of individual patients/clients and health professionals;
- equality among health professions; and
- patient/client access to health care professions of their choice.

Process for Obtaining Input and Comments

Sections I through VI of this publication contain a series of key and supplementary questions that relate to the concepts under review. Written responses to these questions will represent a significant portion of the input requested by the Advisory Council in this Review. Public hearings, focus groups and opinion polling will also be conducted as the Review progresses.

While these activities are underway, the Advisory Council will carry out separate statutory evaluations of the effectiveness of each College's patient relations and quality assurance programs and its procedures for handling complaints and discipline about sexual misconduct. The results of these evaluations will provide additional input for the Review.

When the Review is complete, the *Health Professions Regulatory Advisory Council* will provide the Minister of Health with its recommendations for refining the regulatory system and possible amendments to the RHPA.

About this Publication

Please note, the following materials contain descriptions of the Regulated Health Professions Act and related Acts and is not intended as a definitive legal exposition of the legislation. The reader is advised to consult the actual legislation for specific wording and terminology.

AN OVERVIEW OF THE REGULATED HEALTH PROFESSIONS ACT

In Ontario, more than 220,000 people belong to health professions governed by the *Regulated Health Professions Act* (RHPA).[1]

This Act has been in effect since December 31, 1993 and applies to 23 health professions and the 21 Colleges that regulate them.[2] These 'colleges' are not teaching institutions. Their function is to set standards for one or more health professions and make sure they comply with the RHPA and related laws. Anyone who calls him or herself a regulated health professional must be a member of the College that regulates their profession.

The *Regulated Health Professions Act* provides a common framework for regulating health professions and has several underlying objectives:

- to protect the public from harm;
- to promote high quality care;
- to make regulated health professions accountable to the public;
- to give patient/client access to health care professions of their choice;
- to achieve equality by making all regulated health professions adhere to the same purposes and public interest principles; and
- to treat individual patients/clients and health professionals in an equitable manner.

The RHPA regime consists of the *Regulated Health Professions Act*, the *Health Professions Procedural Code* (Schedule 2), 21 profession-specific Acts, regulations under the Act and profession-specific Acts, and *Ministry of Health Appeal and Review Board Act*. Each of the profession-specific Acts spells out the nature of the specific profession. The *Nursing Act* is one example of such a law.

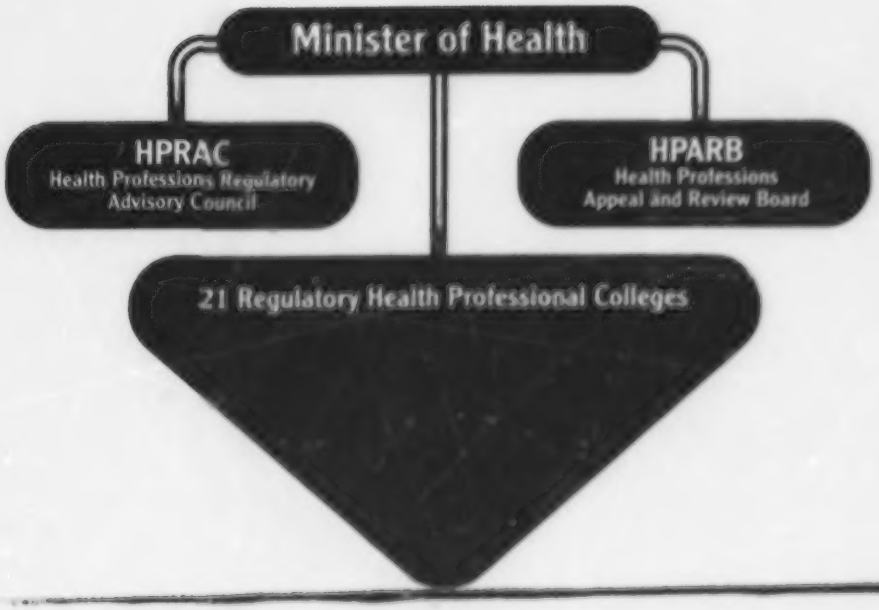
The RHPA assigns duties and responsibilities to:

- the Minister of Health;
- the Colleges that regulate health professions;
- the Health Professions Appeal and Review Board;[3] and
- the Health Professions Regulatory Advisory Council.

1 The Regulated Health Professions Act does not apply to all health professions. Some professions, like Naturopathy, are regulated under another Act. Some professions, like Traditional Chinese Medicine, remain unregulated. They may have voluntary bodies that set standards for their members but have limited ability to enforce such standards.

2 A list of Colleges and the health professions they regulate is contained in Appendix 2. Note that the College of Audiologists and Speech Language Pathologists of Ontario and the College of Chiropodists of Ontario each regulate two different but related professions.

3 See also Ministry of Health Appeal and Review Board Act 1998.



The Minister of Health

The Minister of Health has a duty to make sure Colleges develop and maintain standards for the professions they regulate. The Minister has specific powers under the Regulated Health Professions Act. For example, the Minister may direct a College to:

- find out the state of practice in a particular area or institution;
- provide reports and information about its activities;
- make, change or repeal a regulation made under a health profession Act or the Drug and Pharmacies Act; and [4]
- do anything the Minister believes should be done to carry out the intent of the RHPA, a specific health profession Act or the Drug and Pharmacies Regulation Act.

The Minister may also refer any matter concerning the regulation of health professions to the *Health Professions Regulatory Advisory Council* for its review and recommendations.

Health Regulatory Colleges

Each of Ontario's 21 Health Regulatory Colleges has a Council that acts as its Board of Directors. College Councils are expected to fulfill a number of responsibilities, including to:

- serve and protect the public's interest;
- regulate the practice of one or more health professions;

4 Regulations contain detailed rules or instructions for putting a law into effect.

- set entry to practice standards;
- make sure their members comply with the Acts, regulations, codes and by-laws that apply to their profession;
- set standards of practice for quality care and services;
- promote the continuing competence of members; and
- develop codes of ethics for the professions they regulate.

Each College Council must also maintain and appoint members to the following committees:

- an Executive Committee;
- a Registration Committee;
- a Complaints Committee;
- a Discipline Committee;
- a Fitness to Practice Committee;
- a Quality Assurance Committee; and
- a Patient Relations Committee

College Councils are required to provide reports directly to the Minister of Health. As a further accountability measure, College Councils and most of their committees must have both professional and public members.[5]

The Health Professions Appeal and Review Board

This Board (formerly called the Health Professions Board) is a tribunal whose primary responsibility is to review certain decisions made by College complaints or registration committees when an appeal is made.

Complaint reviews are proceedings during which the Board considers

- the *Complaints Committee's* decision
- the *Complaints Committee's* record of investigation of the complaint; and
- any comments submitted orally or in writing by the person who made the complaint and the College member who is the subject of the complaint.

Either party may request the review and may have a lawyer represent them during the review.

The Board considers the adequacy of the investigation conducted and/or the reasonableness of the decision of the *Complaints Committee*.

When a review is completed, the Board may confirm all or part of the *Complaints Committee* decision, recommend further consideration by the committee, or require the committee to take other action within the committee's powers. The Board has no authority to award money or damages to an individual.

5 The number of professional and public members on each College Council is defined in the Act that deals with the specific profession regulated by the College, but College members are always in the majority and public members are usually just under one half of the total number of members. Public members are "lay persons" appointed by the government.

If a College's *Complaints Committee* does not dispose of a complaint within 120 days, the complainant may appeal the matter to the Board. The Board may direct the *Complaints Committee* to ensure that the complaint is disposed of. If the complaint is not disposed of within a further 60 days, the Board may investigate the complaint and has the powers of the *Complaints Committee* and of the Registrar for investigation of the matter. The Board may even appoint its own investigator. In addition, the Board has all other powers of the *Complaints Committee* or panel, including the ability to make orders and referrals.

The Board also conducts reviews or hearings of registration appeals. These reviews or hearings occur when an individual seeking membership in a College believes its *Registration Committee* has unfairly:

- refused to issue a certificate of registration;
- required the applicant to complete examinations or additional training before receiving a certificate of registration; or
- placed terms, conditions or limitations on the applicant's certificate of registration.

In these situations, applicants have two options. They may ask the Board to review the Registration Committee decision or to conduct a formal hearing. In the case of a review, the applicant and the College provide written submissions for the Board's consideration, but do not appear before it. A hearing, on the other hand, allows both parties to attend, provide sworn testimony and cross-examine one another.

Registration reviews and hearings frequently involve applicants trained and licensed to practice in other jurisdictions. Issues of educational equivalency, training, knowledge and skills often arise during these proceedings.

The Health Professions Regulatory Advisory Council

The *Health Professions Regulatory Advisory Council* (Advisory Council) is an "arms length" agency of the Ministry of Health and reports directly to the Minister of Health through its Chair. Its members are appointed by the government on the recommendation of the Minister of Health. Public servants, Crown employees and past or present members of a College or College Council may not sit on the Advisory Council.

The Advisory Council is responsible for giving the Minister advice about:

- which health professions should be regulated or no longer regulated;
- whether changes should be made to the RHPA or related Acts;
- whether proposed regulations under the RHPA and related Acts should be made;
- whether the Colleges' programs for complaints and discipline in sexual misconduct, quality assurance and patient relations are effective; and
- any other matter concerning the regulation of health professions that the Minister may wish to refer to the Advisory Council.

SECTION I – PROTECTION FROM HARM

About this Section

The main purpose of the *Regulated Health Professions Act* (RHPA) is to protect the public from harm. It does so by placing limits on what health professionals can do and by allowing Colleges to discipline members who ignore these limitations or conduct themselves in an inappropriate way.

Why does the government need to regulate health professionals? Most of us have good reason to trust and respect the professionals who provide our health care services.

However, consider this. The government also regulates those of us who drive. We have to prove that we understand the rules of the road and take a driving test before we get a license. Yet, as we all know, not all licensed drivers are good drivers. Even the best drivers sometimes make mistakes or take chances. If we get careless behind the wheel, we put other people at risk.

Health professionals can make mistakes too. Some of these mistakes can have serious consequences. A physical or emotional problem can affect a health professional's judgement or ability to treat patients/clients properly. Even simple things, such as giving an injection, can be dangerous if not done properly.

The *Regulated Health Professions Act* does not attempt to provide a comprehensive definition of "harm". Instead, the RHPA provides mechanisms that deal with situations in which lack of knowledge, mistakes, carelessness or incompetence have a potential for harm.

The following examples make this point clear. A surgeon makes a serious mistake during an operation. A massage therapist makes a sexual remark to a client. A dental hygienist performs a high-risk procedure, although not authorized to do so under the Act that governs his/her profession. A busy pharmacist dispenses a drug without warning a customer not to use it in combination with another medication. A College Registrar overlooks some weakness in an individual's experience or qualifications and gives them an unconditional certificate of registration to practice.

It is essential that everything possible be done to prevent these sorts of things from happening. That's why the *Regulated Health Professions Act* contains numerous provisions for protecting people from harm. Some of the more important provisions are discussed in this section.

Section Contents

- Registration
- Controlled Acts
- Scope of Practice
- Use of Titles
- Patient Relations Programs
- Mandatory Reporting of Sexual Abuse
- Complaints and Discipline Procedures
- Incapacity Procedures
- Criteria for Regulation of a Health Profession
- Key Questions Concerning Protection of the Public from Harm
- Supplementary Questions

Registration

In Ontario, anyone who wants to call him or herself a regulated health professional must first become a member of the College that governs that profession. If a College Registrar believes the person applying for membership does not meet the necessary standards, a *Registration Committee* must review the applicant's qualifications. Applicants have the right to make written submissions to the Committee or appear before it in person.

When the Committee reaches a decision, it may direct the Registrar to:

- issue, or refuse to issue, a certificate of registration;
- issue a certificate on the condition that the applicant passes certain exams or successfully completes additional training; or
- put specific limitations on the applicant's certificate of registration.

The primary purpose of this process is to prevent individuals who are not fully qualified from performing procedures that could seriously harm their patients/clients. It also gives Colleges an opportunity to determine whether an applicant has the necessary skills, knowledge and training.

Controlled Acts

It is vitally important to regulate health care activities that could seriously harm patients/clients. For this reason, the *Regulated Health Professions Act* (RHPA) lists thirteen procedures that, if not done correctly and by a competent person, have a high element of risk. These "controlled acts" include such things as communicating a diagnosis, giving injections, prescribing hearing aids and delivering babies. Using electricity or certain forms of "energy" to treat a patient/client or diagnose their condition are also examples of a "controlled act".[6]

The RHPA says that no one can perform a controlled act unless the law that applies to their own profession clearly allows them to do so.[7] There are a number of exceptions to this rule, however. For example, a person who is training to become a member of a regulated health profession may perform controlled acts, but only under the direct supervision of a qualified professional. Also, the RHPA allows a member to delegate a controlled act in accordance with the regulations under the College-specific Act governing that member's profession.

Scope of Practice

Members of regulated health professions may not do anything that falls outside their scope of practice. The scope of practice is a description of the profession's activities and the controlled acts that its members are permitted to perform. While it may be obvious that an optometrist could not prescribe a hearing aid, there may be differences in authorized Acts within a profession. For example, some classes of nurses may be able to prescribe a drug while others cannot. These differences must be clearly described in the Acts and regulations that govern each profession.

6 A complete list of controlled acts is included in Appendix 3.

7 When a regulated profession receives the right to perform a "controlled act", the procedure is referred to as an "authorized act".

Use of Titles

The *Regulated Health Professions Act* forbids people from pretending to be members of a regulated health profession. Or, put another way, it ensures that the public can tell which professionals are qualified and held accountable to their Colleges. This means, for example, that people who provide massage services cannot call themselves "massage therapists" unless they are registered with the *College of Massage Therapists of Ontario.*

Use of the title "doctor", any abbreviation of the word doctor, or the equivalent of the word doctor in another language is also restricted. In Ontario, the only health care providers who can use this title are physicians, psychologists, dentists, optometrists and chiropractors.

Patient Relations Programs

The *Regulated Health Professions Act* says that all Colleges must have a patient relations program that includes measures for preventing or dealing with sexual abuse of patients/clients by members. The purpose of such programs, as defined in the Act, is "to enhance relations between College members and patients" by educating College members and informing the public about what is, or is not, appropriate professional conduct.

Mandatory Reporting of Sexual Abuse

The Regulated Health Professions Act defines sexual abuse by a health professional as:

- sexual intercourse or other forms of physical relations with a patient/client;
- touching a patient/client in a sexual manner; or
- behaviour or remarks of a sexual nature to a patient/client.

Members of regulated health professions, and those who operate facilities in which regulated health professions practice, have a legal obligation to report any member who they believe has sexually abused a patient/client. College Registrars must receive these reports not more than 30 days after the alleged offence is committed, but even more quickly if there is reason to believe the member will continue to sexually abuse patients/clients. Colleges may impose a fine of up to $25,000 for failure to report such abuse.

Complaints and Discipline Procedures

Under the provisions of the *Regulated Health Professions Act*, a panel appointed by the College's *Complaints Committee* must conduct an investigation when anyone complains about a member's conduct or actions.

Since people's careers and reputations are at stake, as well as the safety of patients/clients, panels must be as fair as possible. *Complaints Committees* and panels must include at least one member who represents the public.

If a panel of a *Complaints Committee*, after conducting its investigation, believes a College member is incompetent or guilty of professional misconduct, it may do one of the following things:

- refer a specific allegation regarding the member's professional misconduct or incompetence to the College's *Discipline Committee*;
- refer the member to the College's *Executive Committee* for incapacity proceedings;
- refer the member to the *Quality Assurance Committee* if misconduct is related to behaviour or remarks of a sexual nature;
- require the member to appear before the *Complaints Committee* panel or another panel of the *Complaints Committee* to be cautioned; or
- take any action that it considers appropriate, so long as that action is not inconsistent with the *Regulated Health Professions Act*, the health professions act that governs the member's profession, or related regulations and by-laws.

Punishments for members who a College *Discipline Committee* finds guilty of professional misconduct range from a reprimand in less serious cases to permanent removal of their certificate of registration and right to practice. Colleges can also levy fines of up to $35,000 for professional misconduct.

Some Colleges are now using alternate dispute resolution (ADR) processes to handle complaints. These Colleges believe that, in some situations, a less complex and time-consuming process can result in an outcome that satisfies all parties. It is noteworthy, however, that ADR settlements are not part of the public record. The *Regulated Health Professions Act* does not refer to alternative methods for settling disputes since this is a relatively new approach.[8]

Incapacity Procedures

When the *Executive Committee* of a College receives a report from the Registrar that a member may be incapacitated, or receives a referral from a panel of the *Complaints Committee*, the *Executive Committee* may appoint a *Board of Inquiry* to look into whether a member is incapacitated.

If, after making inquiries, the *Board of Inquiry* has reasonable and probable grounds to believe that the member who is the subject of the inquiry is incapacitated, the board may require the member to submit to a physical or mental health examination by a health professional. The Board may also make an order directing the Registrar to suspend the member's certificate of registration until the member has submitted to such an examination.

After receiving the report of the *Board of Inquiry*, the *Executive Committee* may refer the matter to the *Fitness to Practice Committee*. The *Executive Committee* may, subject to certain restrictions in the Act, make an order directing the Registrar to suspend or impose certain conditions or limitations on a member's certificate of registration if it believes that the member is likely to expose patients to harm or injury.

8 ADR is allowed by s.4 and s.4(1) of the Statutory Powers and Procedures Act, which applies to College proceedings.

If a panel of the *Fitness to Practice Committee* finds a member incapacitated, it can make an order:

1. directing the Registrar to revoke the member's certificate of registration;
2. directing the Registrar to suspend the member's certificate of registration; or
3. directing the Registrar to impose specified terms, conditions or limitations on the member's certificate of registration.

Criteria for Regulation of a Health Profession

The government may initiate regulation of a health profession if the Minister of Health believes it necessary to do so in order to promote the public's interest. In addition, a specific profession may seek regulation under the RHPA .

There could be several reasons for making such a request.[9] For example, a profession may believe that regulation will ensure compliance with the profession's standard of practice. Whether initiated by the government or a profession, the Minister may refer the matter to the *Health Professions Regulatory Advisory Council* for advice.

In practice, the review process used by the Advisory Council provides all interested parties an opportunity to make submissions. The Advisory Council may also consult experts who have special knowledge about the application and the profession seeking regulation.

The Advisory Council uses several tests or 'criteria' to guide its thinking. One of these criteria relates to the risk of harm that is associated with the practice of that profession. A complete list of these criteria is provided in Section V-Flexibility (page 30).

Following its review, the Advisory Council provides advice to the Minister. The decision to regulate a new profession is made by Cabinet which then introduces new legislation.

Key Questions Concerning Protection of the Public from Harm

Protecting the public from harm is of utmost importance. Patients/clients and members of the general public cannot be sufficiently protected unless the *Regulated Health Professions Act* (RHPA) contains adequate provisions for achieving this outcome and regulatory Colleges put them into practical effect. Based on your understanding of these provisions and your own experience, please answer the following questions.

1.1

Does the RHPA include provisions that are strong enough and specific enough to provide regulatory Colleges with the tools they need to ensure that individual patients/clients and the general public are sufficiently protected from harm. If not, what additional provisions need to be included in the Act?

1.2

Which RHPA provisions have empowered Colleges to protect individual patients/clients and the public from harm? Which, if any, provisions are barriers to doing so? What improvements are needed?

9 Regulation of a health profession does not guarantee that provincial or private insurance will cover services. A different process is used to determine provincial payment (e.g. OHIP) for services.

1.3

In practice, have the Colleges been able to implement RHPA provisions for the protection of individual patients/clients and the public? If not, what difficulties have been encountered?

1.4

Have Colleges done a good job of implementing RHPA provisions for protecting individual patients/clients and the public from harm? If so, what kinds of initiatives or models of practice do you think have been particularly effective? If not, what general improvements in implementation are needed?

1.5

The issue of lack of referral of complaints to the Discipline Committee of Colleges has been raised. Are complaints being referred to discipline? If not, what are the reasons? Are there any implications for the protection of the public from harm?

1.6

Does the use of alternate dispute resolution (ADR) mechanisms have a deterrent effect and serve to protect the public from harm? If so, under what circumstances? Should ADR settlements be part of the public record? Should there be statutory provisions in the RHPA for Alternate Dispute Resolution?

Supplementary Questions

You do not have to answer all or any of the following specific questions. They are provided here mainly to stimulate your thoughts in responding to the above key questions.

1.a.

In the RHPA, the concept of harm takes on different meanings depending on the context. Has this caused problems in the implementation of the Act?

1.b.

Does the current list of controlled acts adequately cover the full range of procedures that can cause significant risk of harm? Should any procedures be added to or removed from the list of controlled acts?

1.c.

Are the title protection provisions sufficient to avoid confusion for the public? For example, do they adequately differentiate between regulated and unregulated practitioners?

1.d.

Are there sufficient provisions to support enforcement of the Scope of Practice regime, including controlled acts and title protection?

1.e.

Are the current provisions on delegation under the College-specific Acts sufficient to protect the public from harm? Does the lack of a definition and absence of any limit on delegation in the RHPA put the public at risk?

1.f.

Should the RHPA clearly define what constitutes a complaint? If so, how should "complaint" be defined?

1.g.

Should the RHPA include specific and comprehensive definitions of what constitutes physical and verbal patient abuse?

1.h.

Are the provisions that require health professionals to make mandatory reports of sexual misconduct by their colleagues adequate for the protection of the public from harm? If not, how can reporting of such cases be increased?

1.i.

Is professional incompetence or incapacity being reported by colleagues/employers to the professional's College Registrar? If not, how can reporting of such cases be increased?

1.j.

Are the provisions that require employers to report the termination of a health professional's employment due to incapacity and incompetence adequate for the protection of the public from harm?

1.k.

Are the provisions for complaints and discipline processes for misconduct other than that of a sexual nature adequate for the protection of the public from harm?

1.l.

Are mandatory reports and complaints being treated differently? If so, are there any implications for protection of the public from harm?

1.m.

Should the RHPA be more specific about the types of complaints that should be dealt with by Discipline Committees?

1.n.

Does the RHPA adequately provide for information to and education of the public? If not, what additional provisions are required?

1.o.

Should the RHPA specify more components for the Patient Relations program than just sexual abuse protection? Are the current statutory components of the Patient Relations programs sufficient? Are they implemented adequately?

1.p.

Should there be specific provisions for enforcement of the "risk of harm" clause in s.30(1) in the RHPA? [10]

1.q.

Do health professions without controlled acts need to be regulated? If so, should they be regulated under the RHPA or through alternate forms of regulation?

1.r.

Are the criteria for regulation of a new health profession under the RHPA adequate to protect the public from harm? Are these criteria sufficient, excessive or appropriate as they are?

10 Section 30(1) states: "No person, other than a member treating or advising within the scope of practice of his profession shall treat or advise a person with respect to his or her health in circumstances in which it is reasonably foreseeable that serious physical harm may result from the treatment or advice or from an omission from them."

SECTION II – QUALITY OF CARE

About this Section

High quality care is difficult to measure or define because it is partly subjective. In other words, it may mean different things to different people at different times and in different circumstances. Perhaps that's why those who framed the Regulated Health Professions Act (RHPA) didn't attempt to define it. Instead, the RHPA gave regulatory Colleges the authority to:

- assess the skills, knowledge and judgement of prospective members,
- develop and maintain standards of practice;
- provide quality assurance programs;
- promote continuing competence among their members; and
- when necessary, assess a member's competence or fitness to practice.

For individuals working in a regulated health profession, quality of care involves such things as:

- keeping up to date with the latest developments in one's field;
- taking care to correctly diagnose or assess a patient's/client's condition;
- using the best available tools and treatment methods;
- prescribing or recommending the right drugs or substances and taking the time to warn patients/clients of possible side effects;
- exercising good judgement when dealing with difficult cases; and
- treating patients/clients with dignity, sensitivity and respect.

High quality care may be difficult to define, but the people of Ontario should expect and receive no less. This section deals with RHPA provisions that help achieve that outcome.

Section Contents

- College Purposes
- Entry to Practice Provisions
- Quality Assurance Programs
- Quality Assurance Committees
- Evaluating Quality Assurance Programs
- Standards of Practice and Clinical Guidelines
- Competency Reviews
- Key Questions Concerning Quality of Care Provisions
- Supplementary Questions

College Purposes

The Regulated Health Professions Act (RHPA) lists purposes for Health Regulatory Colleges. Some of these are:

- to regulate the practice of the profession and to govern members in accordance with the RHPA and related regulations and by-laws;
- to develop and maintain qualification standards for their members;
- to develop and maintain programs and standards of practice which assure quality care;
- to develop and maintain standards of knowledge and skill and programs that promote continuing competence among their members;
- to develop and maintain standards of professional ethics for their members; and
- to exercise their rights under the RHPA.

The collective focus of these purposes is to maintain and improve the overall performance of health professionals and to achieve better outcomes for their patients/clients. This process begins with a careful evaluation of individuals who wish to enter a regulated health profession.

Entry to Practice Provisions

In Section 1, we described the procedure that's used to determine whether people who apply for College membership are fully qualified to practice their chosen profession. An important function of this screening process is to find out whether applicants have the skills, knowledge and judgement needed to give their patients high-quality care. Colleges may:

- refuse to register an applicant who does not meet College requirements;
- require those who do not meet their standards to take extra training or successfully complete certain exams before getting their certificate of registration; or
- put specific terms, conditions and limitations on an applicant's certificate of registration and monitor their progress on an ongoing basis.

Quality Assurance Programs

Team-based management programs such as Continuous Quality Improvement and Total Quality Management have been used in the manufacturing sector for many years, but are a recent development in the health care field. Ontario's leadership in this area is reflected in the Regulated Health Professions Act requirement that Colleges develop Quality Assurance programs for the professions they govern.

The Ministry of Health has developed guidelines for the development of Quality Assurance programs. These guidelines recommend that Colleges develop programs with components that:

- maintain and improve the competence of individual members;
- raise the collective performance of the profession by focusing on improved patient/client outcomes; and
- identify and provide ways of dealing with members who are incompetent.

These guidelines give Colleges the flexibility to develop Quality Assurance Programs that best meet the needs of the professions they regulate, but all such programs have several things in common. For example, Colleges have an obligation to promote and maintain their members' competence through continuing education programs. Educational institutions generally provide such programs, but members may also be required to successfully complete examinations that Colleges hold from time to time.

It's important for people in any trade or profession to improve their knowledge and skills, but it's vital that members of regulated health professions do so.

Quality Assurance Committees

Under the provisions of the *Regulated Health Professions Act*, each College must appoint a *Quality Assurance Committee*. These committees are responsible for conducting peer reviews relating to the quality of care provided by their fellow members.

Quality Assurance Committees have broad powers to investigate the conduct or standards of practice of College members. Their objective is not to punish health professionals but, whenever possible, to apply measures that improve the quality of care provided by individual members and the profession as a whole. When necessary, however, a *Quality Assurance Committee* can refer a case to the *Executive Committee*, which in turn may refer the case to the *Fitness to Practice* or *Discipline Committee*. Ultimately, the College Registrar may be directed to impose terms, conditions or limitations on the certificate of registration of any member:

- whose knowledge, skills and judgement have been assessed or reassessed and found to be unsatisfactory; or
- who has failed to participate in or successfully complete continuing education programs or remedial training specified by the Committee.

It's important to note that the College can and will remove such terms, conditions or limitations when it is satisfied they are no longer needed.

The Regulated Health Professions Act also authorizes *Quality Assurance Committees* to appoint "Assessors" who have the right to enter places where College members practice and inspect any accounts, reports and records relating to the care of patients/clients and the quality of such care.

The member whose premises and records have been inspected may be required to appear before the *Quality Assurance Committee*. They may also be required to take part in a process designed to test their competence and judgement.

Quality Assurance Committees also have a responsibility to deal with a complaint concerning alleged sexual misconduct referred to them by a panel of the

Complaints Committee. The *Quality Assurance Committee* can then compel the member to attend a program or to take part in continuing education. Education or counselling is appropriate in cases where the sexual abuse involved inappropriate behaviour or remarks. In these situations, the member needs to develop a better understanding of what is inside or outside the bounds of appropriate conduct or behaviour.

Evaluating Quality Assurance Programs

The Regulated Health Professions Act provides an independent and impartial process for judging the effectiveness of quality assurance programs. The *Health Professions Regulatory Advisory Council* has a statutory duty to review the effectiveness of each College's Quality Assurance programs and report its findings to the Minister. The Advisory Council's review is now underway.

Standards of Practice and Clinical Guidelines

Standards of practice clarify what members are expected to do and under what circumstances. Colleges may also establish clinical guidelines for the health professions they regulate. These guidelines describe accepted policies and procedures for dealing with specific situations. Their purpose is to help members make appropriate judgements and decisions when considering possible courses of action.

Competency Reviews

The vast majority of health professionals are knowledgeable, capable and committed to giving their patients/clients the best possible care. However, as in any other field, there are a few exceptions. Some individuals may simply have failed to keep up with developments in their field. The skills of others may have diminished over time. In the final analysis, however, incompetence is incompetence and it must be addressed.

The *Regulated Health Professions Act* says that a *Discipline Committee* panel must find a member incompetent if:

- the member's professional care of a patient/client displayed a lack of knowledge, skill or judgement; or
- the member demonstrated sufficient disregard for the welfare of the patient/client that the member is unfit to practice or should have restrictions placed on his or her practice.

If a *Discipline Committee* panel finds a member incompetent, it may make an order that directs the College Registrar to:

- revoke the member's certificate of registration; or
- suspend the member's certificate of registration; or
- impose specific terms, conditions and limitations on the members certificate for a specified or indefinite period.

In making these orders, a panel may specify criteria to be satisfied before such terms, conditions and limitations are removed.

Key Questions Concerning Quality of Care Provisions

Patients/clients should expect and receive high quality care from regulated health professionals. If the *Regulated Health Professions Act* (RHPA) is to be effective in maintaining and promoting such quality of care it must provide regulatory Colleges with sufficient provisions for implementing this objective. Based on your understanding of the RHPA's current provisions and your own experience, please answer the following questions.

2.1

Does the RHPA include provisions that are strong enough and specific enough to provide regulatory Colleges with the tools they need to ensure that their members provide high quality care? If not, what additional provisions need to be included in the Act?

2.2

Which RHPA provisions have empowered Colleges to maintain and promote quality care? Which if any provisions are barriers to doing so? What changes or improvements would you suggest?

2.3

In practice, have the Colleges been able to implement RHPA provisions for the maintenance and promotion of quality care? If not, what difficulties have they encountered?

2.4

Have Colleges done a good job implementing RHPA provisions for the maintenance and promotion of quality care? If so, what kinds of initiatives or models of practice have been particularly effective? If not, what general improvements in implementation do you suggest?

Supplementary Questions

You do not have to answer all or any of the following specific questions. They are provided here mainly to stimulate your thoughts in responding to the above key questions.

2.a.

The RHPA requires each College to establish a program to assure the quality of practice of the profession and to promote continuing competence among its members. Is this requirement of Colleges sufficient to promote quality care? Do Colleges need additional mechanisms to supplement Quality Assurance programs in order to maintain and promote quality care?

2.b.

Should detailed Quality Assurance program requirements be specified in the RHPA, in regulations, in by-laws, or as part of each profession-specific Act?

2.c.

Should standards of practice be included in the legislation? Why or why not?

2.d.

Are Quality Assurance program assessors able to access all workplaces? If not, what barriers exist and what suggestions do you have for improvements?

SECTION III - ACCOUNTABILITY

About This Section

This section deals with the legal obligations of Colleges and their members to serve and protect the public interests and be accountable to individual patients, clients and the public at large. The Regulated Health Professions Act contains many rules that deal with accountability, but we have chosen to highlight those that are of special importance to the public.

Section Contents

- Structure of College Councils
- Council Responsibilities and Powers
- Patient Relations Programs
- College Registers
- Complaints and Discipline Process
- Public Disclosure Provisions
- The Advisory Council's Composition
- Key Questions Concerning Accountability
- Supplementary Questions

Structure of College Councils

Each College has a Council that acts as a Board of Directors. Although the composition of these Councils varies, ***all*** Councils must have public members who are not regulated health professionals. The Act that deals with a specific health profession specifies the number of public and professional members on each College Council, but professional members are always in the majority. The government appoints public members, while the College membership elects professional members.

An *Executive Committee*, which handles matters that require urgent attention between Council meetings, must also have at least one public member. The same rule applies to College committees or panels that deal with member registration, complaints, discipline and fitness to practice.

The public has a right to attend Council meetings. Councils may only make an exception to this rule if there is a very good reason to do so. For example, Council meetings sometimes deal with public security issues or with College members who are involved in criminal or civil proceedings. In these situations, a Council must weigh the public's 'need to know' against the damage that could be caused by disclosing sensitive information. When a Council does decide to close a meeting or part of a meeting to the public, its reasons for doing so must be clearly stated and included in the minutes.

Council Responsibilities and Powers

A College Council's primary responsibility is to govern the profession in the public interest by making sure its members comply with the *Regulated Health Professions Act* (RHPA) and are accountable to the public. The RHPA promotes public accountability by having Colleges report annually to the Minister of Health and by requiring College Councils to include public members.

Council duties include the development and maintenance of standards concerning College membership requirements, scope of practice, quality assurance and professional ethics.

College Councils also have the authority to make 'regulations' under their own profession-specific Act.[11] Regulations are usually written after a law has been passed by the Ontario Legislature. They are separate from an Act, but have the same legal force as the Act itself. The Minister of Health must review proposed College regulations. College Councils can make over 15 different types of regulations. From the public's point of view, some of the more important regulations are those that:

- relate to promotion or advertising by members;
- define professional misconduct;
- define conflict of interest;
- govern or prohibit the delegation of controlled acts by or to members; and
- require members to keep specific records relating to their practice.

11 Cabinet must pass proposed College regulations. These regulations cannot be put into effect until they are approved by the Cabinet and signed by the Lieutenant Governor of Ontario.

Patient Relations Programs

The Regulated Health Professions Act requires each College to have a patient relations program that promotes measures for preventing or dealing with sexual abuse of patients/clients including funding for therapy and counselling. The purpose of these programs is to educate College members and inform the public about what is, or is not, appropriate professional conduct. These programs are another important mechanism for providing public accountability.

College Registers

Each College must keep a Register that contains information about each of its members. For example, the Register must include information that indicates:

- whether the College has placed any terms, conditions or limitations on the member's certificate of registration;
- whether the member has been found to be incompetent or guilty of professional misconduct and, if so, what action was taken against the member;
- whether the member's certificate of registration has ever been suspended or revoked; and
- whether a *Disciplinary Committee* decision is currently being appealed.

Anyone, including members of the public, can obtain this and other information for the last six years, upon payment of a reasonable fee to cover copying costs, from the College Registrar.[12] Not all information on the Register is accessible to the public. An example of this is information about a finding of incapacity which is no longer publicly accessible once a member's certificate of registration is reinstated.

Complaints & Discipline Process

In Section I, we described the process for handling complaints about a College member's conduct, capability or fitness to practice. Public accountability is an important aspect of the complaints and discipline process. All formal complaints, whether made by a College member, a patient/client or another party must be investigated by a *Complaints Committee* panel.

This panel, which must have at least one public member, reviews all evidence or submissions that support or dispute the complaint.

If the panel decides the complaint is valid, it may refer the matter to another committee for possible disciplinary action.[13]

The College must notify everyone who is directly involved in a complaints process about its decisions, the reasons for such decisions, and their right to appeal to the Health Professions Appeal and Review Board.
Individuals who make a complaint, or are the subject of a complaint, may also appeal to the Board if the matter is not settled within 120 days.

12 A Registrar is ***not*** required to provide a member's business address or telephone number if there is reason to believe this information might threaten the member's safety.

13 If the *Complaints Committee* panel believes the member is mentally or physically incapable of practising, it must refer the matter to the College's *Executive Committee* which can order an incapacity hearing.

Public Disclosure Provisions

Each College must include, in its annual report, a summary of the decisions it reached after conducting discipline hearings. The College must also list the panel's reasons for making such decisions.

Information concerning members found guilty of professional misconduct by a *Discipline Committee* must be included in the College Register. As mentioned above. this information is available to the public.

Information concerning a ***complaint*** that has not resulted in discipline is not included in the College Register and cannot be published.

As we noted in Section I, some Colleges are now using alternate dispute resolution processes to handle complaints. Alternate Dispute Resolution (ADR) is a process that attempts to resolve disputes to the mutual satisfaction of both parties without resorting to lengthy and expensive reviews or hearings.

Since ADR settlements involve a health care professional and a College, and are private, information about such agreements is not included in the College Register and is not available to the public.

Health Professions Regulatory Advisory Council

In concluding this section, it is important to note that responsibility for reviewing the impact and effectiveness of the *Regulated Health Professions Act* was assigned to the *Health Professions Regulatory Advisory Council* (Advisory Council) in a request from the Minister of Health.

The Advisory Council is an impartial arms' length agency of the Ministry of Health whose government-appointed public members cannot be public servants, Crown employees or past or present members of a regulatory College or College Council. The Advisory Council's statutory responsibilities are outlined in this document's Overview of the *Regulated Health Professions Act*.

Key Questions Concerning Accountability

Health professionals must be accountable to their patients/clients and the public. Colleges also have an obligation to serve the public interests and are accountable to the public for this responsibility.

Effectiveness of the Regulated Health Professions Act (RHPA) in maintaining and promoting accountability among health professionals requires that the RHPA set out sufficient provisions for accountability and that such provisions are implemented optimally by the regulatory Colleges.

Based on your understanding of RHPA provisions concerning accountability and your own experience, please answer the following questions:

3.1

Does the RHPA include provisions that are strong enough and specific enough to ensure accountability of Colleges to the public and accountability of health professionals to their patients/clients and the public? If not, what additional provisions need to be included in the Act?

3.2

Which RHPA provisions have helped to maintain and promote the accountability of Colleges and health professionals to their patients/clients and the public? Which provisions, if any, are barriers to doing so? What improvements are needed?

3.3

In practice, have the Colleges been able to implement the provisions of the RHPA for the maintenance and promotion of accountability of health professionals to their patients/clients and the public? If not, what difficulties have been encountered?

3.4

Have the Colleges done a good job of implementing RHPA provisions for maintaining and promoting the accountability of health professionals to their patients/clients and the public? If so, what kinds of initiatives or models of practice do you think have been particularly effective? If not, what general improvements in implementation are needed?

3.5

What is the appropriate mix of public members and health professionals on College Councils? Should the majority of College Council members continue to be health professionals elected by their colleagues, or should greater regulatory control be placed in the hands of public members appointed by the Cabinet?

Supplementary Questions

You do not have to answer all or any of the following specific questions. They are provided here mainly to stimulate your thoughts in responding to the above key questions.

3.a.
Are there sufficient numbers of public members on College Councils to effectively represent the public's interest?

3.b.
Are there sufficient numbers of public members on *Complaints and Discipline Committees* to effectively represent the public's interest?

3.c.
Are public members sufficiently equipped to represent the interests of the public (e.g., orientation, training, financial support)? If not, what approaches could be used to better equip public members for their role?

3.d.
Should College Councils contain representatives from different regulated health professions?

3.e.
Is the publicly accessible information in College registers sufficient to protect the public from harm? For example, should the public have access to information about ADR settlements and orders for remedial training from the *Quality Assurance Committee*?

3.f.
Should the College's *Executive Committee's* powers and procedures be clearly defined in the legislation?

3.g.
Do College members understand the public interest mandate of the College?

3.h.
Are professions being regulated in the public interest or in the interest of their members?

3.i.
Should additional mechanisms be put into place to maintain/promote the ongoing effectiveness of self-regulation of health professions (e.g., continued statutory evaluations by the Advisory Council, more defined Ministry of Health functions, a 10-year review)?

3.j.
Are the powers of the Minister insufficient, adequate or excessive?

3.k.
Has public input to the regulatory system through the Advisory Council been sufficient, adequate or excessive?

SECTION IV - EFFICIENCY

About this Section

Throughout history, humans have struggled to become more efficient—to do more in less time and with less effort. In 1605, a French mathematician named Blaise Pascal invented a cog-driven mechanical device that used wheels numbered from zero to nine to add and subtract. He called it a 'computer'. In today's world, the electronic 'offspring' of Pascal's mechanical 'computer' have increased the efficiency of many tasks and functions in society. We are able to do more things in less time, with less effort and fewer resources. But to achieve what ends? To preserve which values?

The challenge that now faces Ontario's Health Professions Regulatory Colleges is to operate in an efficient and timely way, without compromising effectiveness, flexibility, and fairness. In this section, we discuss some of the more resource intensive and time-consuming requirements of the Regulated Health Professions Act and pose questions about their impact on regulatory Colleges, health professionals, patients/clients and the public.

Section Contents

- Regulatory and Administrative Requirements
- Complaints and Discipline Requirements
- Quality Assurance Program
- Patient Relations Program
- Key Questions Concerning Efficiency
- Supplementary Questions

Regulatory and Administrative Requirements

Responsibilities such as developing registration, ethical and quality assurance standards consume much of a College's time. In addition, Colleges also:

- conduct administrative, financial and internal affairs;
- develop by-laws and regulations;
- communicate with their members;
- manage large numbers of committees;
- prepare committee reports and recommendations; and
- prepare annual reports and College publications.

All of these tasks place considerable demands on College resources. However, the complaints and discipline process and the quality assurance and patient relations programs are among the most resource-intensive College requirements. These are dealt with in greater detail below.

Complaints and Discipline Requirements

The *Regulated Health Professions Act* says Complaints Committees must settle formal complaints about the conduct of their members within 120 days.

During this time, Colleges must:

- give the member notice and 30 days to prepare a written response;
- appoint a complaints committee panel;
- investigate the complaint;
- review material provided by the member, the person who made the complaint and any other evidence that has a bearing on the case;
- consider possible courses of action; and
- refer the matter to another panel or committee if further action is indicated.

The length of time required to settle complaints is also a public concern. Complainants have a right to ask the *Health Professions Appeal and Review Board* to intervene if a College does not dispose of a complaint within 120 days.

As we noted in Section I, some Colleges are now using alternate dispute resolution processes to handle complaints. Alternate Dispute Resolution (ADR) is a process that attempts to resolve disputes, to the satisfaction of both parties, without resorting to lengthy and expensive reviews or hearings. Although alternate dispute resolution may be efficient, private settlements between a complainant and a health care professional are not subject to review or public scrutiny. In some people's minds, this raises questions about efficiency versus accountability.

Quality Assurance Program

In Section II, we discussed the *Regulated Health Professions Act* requirement that Colleges develop quality assurance programs. We also described the process for assessing members' conduct and standards of practice. The process leading up to the application of corrective measures can be lengthy, time consuming and expensive.

Quality assurance programs are relatively new in the health care field and there are widely different opinions about how to measure or ensure quality care and determine what College resources should go into these programs. Quality assurance programs also put demands on health care professionals. They must take time away from their practice to upgrade their skills and knowledge and take part in College assessments designed to measure their competence and ability to provide high quality care.

Patient Relations Program

One of the main objectives of the provisions of the *Regulated Health Professions Act* is to eradicate sexual abuse by health professionals. Patient relations programs, which all Colleges are required to develop and maintain, are one mechanism for doing so. Their purpose is to educate regulated health professionals and inform the public about what is and is not appropriate professional conduct. Providing information to health professionals and the public can, potentially, demand a lot of College resources.

The effectiveness of these programs is currently being evaluated by the *Health Professions Regulatory Advisory Council*. These evaluations place extra demands on College staff and health professionals alike.

Key Questions Concerning Efficiency

Efficiency is about minimizing the time and effort necessary to achieve the desired outcomes. In the case of the *Regulated Health Professions Act*, these outcomes include protection of the public from harm, provision of high quality care, promotion of accountability and preservation of principles such as flexibility and fairness. Based on your understanding of the time and effort needed to achieve these outcomes, please answer the following questions.

4.1

Have any of the *Regulated Health Professions Act* (RHPA) requirements been cumbersome or placed excessive demands on Colleges? Could these requirements be simplified or streamlined without compromising the effectiveness of the RHPA?

4.2

Have the RHPA provisions placed excessive demands on patients/clients? If so, how can the RHPA better accommodate their needs and requirements?

4.3

Have Colleges been able to make the best use of available resources to achieve the RHPA's desired outcomes? If not, why not?

4.4

Could collaboration between and among Colleges increase their efficiency? Are there any barriers to Colleges sharing resources? If so, what are they?

4.5

Could efficiencies in the system be gained by merging some of the Colleges? If so, what criteria should be used to determine whether mergers should be considered?

4.6

Could less costly mechanisms or approaches be used to achieve the RHPA's desired outcomes? If so, what are they?

4.7

Has implementation of the RHPA allowed the Minister of Health to make timely decisions regarding new legislation or legislative amendments? What improvements would you suggest?

Supplementary Questions

You do not have to answer all or any of the following specific questions. They are provided here mainly to stimulate your thoughts in responding to the above key questions.

4.a.

Are the required timelines for College decisions and appeals feasible?

4.b.

Should Colleges whose members have little or no patient/client contact be exempt from having Patient Relations programs?

4.c.

Are there barriers to the efficient operation of College Councils? If so, what are they?

4.d.

Do RHPA provisions regarding public appointments (e.g., quorums, statutory minimums) allow for efficient operation of the College Council?

4.e.

Are the registration fees of Colleges insufficient, adequate or excessive?

4.f.

Have provisions of the RHPA and the College-specific Acts been amended with relative ease when necessary?

SECTION V - FLEXIBILITY

About This Section

Keeping abreast of new technologies, diagnostic procedures, and methods of treatment has become an ever-increasing challenge for health professionals. During the past decade, Ontario's population has become better educated, more discriminating, and more involved in their own health care.

There have been shifts in the relationships among health care professions, as well as changes in the distribution of health care professionals and the way in which services are provided. Caring for people from different cultures and with widely different beliefs, values and expectations, requires sensitivity, understanding and flexibility.

This section deals with such realities, and the regulatory system's readiness to adapt to changing needs and circumstances.

Section Contents

- Minister's Latitude to Direct Change – What can the Minister do?
- The Public's Ability to Influence Change
- College's Latitude in Making Regulations and By-laws
- Flexibility to Exempt Individuals from Performing Controlled Acts
- Key Questions Concerning Flexibility
- Supplementary Questions

Minister's Latitude to Direct Change – What Can the Minister Do?

Provisions for adapting to changing times and circumstances are summarized in Section 5 (d) of the *Regulated Health Professions Act* (RHPA), which reads as follows:

"The Minister may require a (College) Council to do anything that, in the opinion of the Minister, is necessary or advisable to carry out the intent of this Act, the health professions Acts or the *Drug and Pharmacies Regulation Act*."

This section of the *Regulated Health Professions Act* gives the Minister of Health considerable latitude to respond to changing needs and circumstances. Under the current provisions of the Act, the Minister could, for example:

- require Colleges to share administrative and other resources; or
- broaden the scope of patient relations programs (which now deal predominantly with sexual abuse).

However, there are many other changes that, if necessary or desirable to accommodate evolving needs, would require legislative amendments, which involves a time-consuming process. Such changes could:

- limit or expand a regulated health profession's scope of practice;
- expand the number of "controlled acts" that can be performed by health professionals or limit their ability to delegate such acts to others;
- regulate a new profession or deregulate an existing one; or
- alter current exemptions under the Act.

The Public's Ability to Influence Change

The Minister also has an obligation, on request from a College Council or a person, to refer any matter concerning the regulation of health professions to the *Health Professions Regulatory Advisory Council* (Advisory Council).

The Advisory Council's primary responsibility is to conduct public reviews, on the Minister's behalf, concerning proposed changes to the laws and regulations that govern regulated health professions. Anyone, including members of the public, can ask the Minister to refer such matters to the Advisory Council. Members of the public can also participate in Advisory Council reviews concerning the regulation of health professions.

The fundamental objective in this review process is to determine whether regulation of the profession is necessary and in the public interest. The Advisory Council uses nine criteria for making this determination. These criteria are applied in the following questions:

1. Is a substantial percentage of the profession's membership engaged in activities that are under the Minister of Health's jurisdiction and have, as their primary objective, the promotion or restoration of health?
2. Do the services provided by the profession pose a substantial risk of physical, emotional or mental harm to their patients/clients?
3. Do members of the profession work in settings where there is no effective monitoring or supervision of their performance?
4. Is the profession unlikely to be regulated under some other regulatory mechanism?
5. Must members of the profession rely upon a distinctive, systematic body of knowledge when assessing or treating their patients/clients?
6. Are members of the profession required to successfully complete a post-secondary program offered by a recognized Canadian educational institution before being admitted to their profession?
7. Has the profession's leadership demonstrated its ability and desire to place the public's interest ahead of its own interests?
8. Is there sufficient member support for self-regulation that widespread compliance with legislation is likely?
9. Does the profession have enough qualified and committed members to staff all committees of a governing body and maintain a separate professional association?

This process ensures fairness by giving all interested parties, including members of the public, an opportunity to state their views. The Advisory Council may also consult experts who have special knowledge about the application and the profession seeking regulation. Regulatory review proceedings are open to the public and, when necessary, make special accommodation for individuals with special needs.

In making its recommendations to the Minister, the Advisory Council relies exclusively on information that is a matter of public record. The Advisory Council's role is strictly advisory. Decisions are made by the Minister.

College's Latitude in Making Regulations and By-Laws

If the *Regulated Health Professions Act* is to remain relevant, it must be flexible enough to respond to the changing needs of consumers and health professionals. For this reason, regulatory Colleges have the authority to make regulations that define or re-define the responsibilities, obligations and standards of practice of their members.[14] For example, a College might choose to enact regulations which:

- set different standards for professionals seeking College membership;
- introduce new measures for ensuring compliance with quality assurance programs; or
- define conflict of interest for members of the profession.

College Councils also have the flexibility to modify or streamline their internal and administrative procedures by passing by-laws that, for example, set fees and election processes or change the composition and duties of some committees.[15]

Flexibility to Exempt Individuals from Performing Controlled Acts

The *Regulated Health Professions Act* (RHPA) does not apply to aboriginal healers and midwives who are providing traditional healing or midwifery services to members of an aboriginal community. Individuals who counsel others about emotional, social, educational or spiritual matters, or treat others by prayer or spiritual means, are also exempt from "controlled acts" provisions.

Key Questions Concerning Flexibility

Ontario is a diverse and dynamic society. For the RHPA to remain relevant, it must be flexible enough to respond to diversity in the current environment as well as to the evolving needs of consumers and of health professionals in a changing environment. The following questions seek input on whether implementation of the RHPA has been responsive to current and emerging needs.

5.1

Have provisions in and implementation of the RHPA been flexible enough to respond to the evolving practices of regulated health professions, such as innovations in practice and technological advancements?

5.2

Have provisions in and implementation of the RHPA been flexible enough to respond to changing practice environments which change supervisory arrangements, required expertise, and opportunities for consultation and collaboration with peers?

5.3

Have provisions in and implementation of the RHPA been flexible enough to respond to changing consumer expectations and needs?

14 Regulations are subject to review by the Minister of Health and do not come into effect until they are approved by the government.

15 In February 1999, Bill 25, the *Red Tape Reduction Act*, gave Colleges greater flexibility by increasing the scope of their by-law making powers.

Supplementary Questions

You do not have to answer the following specific questions. They are provided here mainly to stimulate your thoughts in responding to the above key questions.

5.a.

In practice can regulation of new professions and deregulation of existing health professions be initiated and carried out with ease?

5.b.

Does the shift toward more community-based care have implications for the regulatory system?

SECTION VI – FAIRNESS

About This Section

Much of this publication has been devoted to describing *Regulated Health Professions Act* (RHPA) provisions for protecting the public from harm, promoting quality care and holding professionals accountable.

This section deals with the equally important need to ensure that the RHPA is implemented in a way that is just, impartial, equitable and accessible to ***all*** concerned parties, including those who govern and provide health care services.

It speaks to accessibility, including the right of individuals to obtain services from the health professions of their choice. It speaks to the public's right to complain about the conduct of health professionals and the right of College members to defend themselves and receive a fair hearing.

It talks about equality through RHPA provisions that make all regulated health professions adhere to the same corporate structure, purposes, procedures and public interest principles.

It deals with equity and the expectation that the interests/rights of those who receive as well as those who provide health care services will be respected and that they will be treated with dignity.

Last, but not least, this section speaks to the need to balance the rights and powers of Colleges, health professionals and members of the public.

Section Contents

- Applications for College Membership
- Complaints Procedures
- Mandatory Reporting of Sexual Abuse
- Health Professions Appeal and Review Board Hearings
- Appeals to the Court
- Key Questions Concerning Fairness
- Supplementary Questions

Applications for College Membership

In Ontario, any health care provider who wants to call him or herself a regulated professional must first become a member of the College that governs his or her profession. In earlier sections of this publication, we described the process for doing so and for evaluating a person's skills, knowledge and experience.

The *Regulated Health Professions Act* provides two ways of making sure this procedure is fair to applicants and that Colleges will not have to issue certificates of registration to unqualified individuals.

If a College Registrar asks the College's Registration Committee to review an application, the individual making the application has the right to make written submissions to the committee.

If the committee, after reviewing the application, a) refuses to issue a certificate to the applicant, b) requires the applicant to pass certain exams or successfully complete additional training, or c) puts specific limitations on the applicant's certificate of registration, the applicant may appeal the committee's decision to the *Health Professions Appeal and Review Board*

In these situations, the Board can either review written copies of the individual's application and the *Registration Committee's* decision or conduct a full hearing involving sworn testimony and cross-examination of witnesses. The applicant has a right to decide which process the Board uses.

Complaints Procedures

The way in which a College handles complaints about its members is one of the most important tests of its ability to regulate a profession and to balance the rights of the public against those of its members.

In Ontario, everyone has a legal right to make a complaint about the conduct of a regulated health professional and to have their complaint investigated by the College to which the professional belongs. Most complaints come from patients/clients or family members, but a professional's colleagues also have a right to register complaints.[16]

Colleges are required to investigate ***all*** complaints, including those made by people who were not directly involved. There is no fee for registering a complaint and there is no time limit for doing so.

The first step in the process is to submit a complaint to a College Registrar. Complaints must either be made in writing or in some other recorded form, such as video or audiotape.

Although they are not required to do so, many Colleges are willing to assist members of the public to prepare or clarify their complaints.

16 Regulated health professionals also have a legal obligation to report members who they believe have sexually abused a patient or client.

A three-member panel appointed by the College's *Complaints Committee* is usually responsible for handling complaints, although the full committee is sometimes involved in such reviews. These panels, and the *Complaints Committees* that appoint them, must include at least one public member.[17]

When a complaint is registered, the College Registrar must give the member notice of the complaint and 30 days to prepare a written response to the allegation. *Complaints Committee* panels must also make a reasonable effort to consider any other records or documents that may have a bearing on the matter.

Complainants and members do not have a right to request a meeting with *Complaints Committee* panel members or to attend panel meetings. However, they may be invited to appear before the panel or even to meet together in an effort to resolve the matter.

The panel has 120 days in which to complete its investigation and give written notice of its decision to the member and the person who made the complaint.

If the panel dismisses the complaint, takes only minor action, or refers it to the College's *Quality Assurance Committee* it must also give the complainant and respondent a written copy of its reasons for doing so. The panel must also tell the member and the person making the complaint whether they have the right to appeal its decision to the *Health Professions Appeal and Review Board.*

Neither the member nor the person making the complaint can appeal to the Board if a panel decides to refer the matter to the College's *Discipline Committee* or its *Executive Committee* for further consideration.

Mandatory Reporting of Sexual Abuse

Under the provisions of the *RHPA,* members of regulated health professions have a legal obligation to notify their College if they have reason to believe a regulated health professional has sexually abused a patient/client. The College must investigate all such allegations. This provides for a reporting mechanism in cases where victims of sexual abuse may be afraid or unable to complain on their own behalf. This is especially important in the case of people who are vulnerable or disadvantaged (e.g., persons with developmental disabilities).

Victims of sexual abuse by a College member may also be entitled to counselling and therapy and all Colleges must provide funding for this purpose. Some Colleges may also require members who committed sexual offences to repay this money.

17 Committee or Committee panel public members are "lay persons" appointed by the government.

Health Professions Appeal and Review Board Hearings

If it is their desire to do so, complainants or College members must request a Board review within thirty days of receiving notice of a complaints panel decision. The Board can extend this time limit for an additional 60 days if it is satisfied that no person will be prejudiced. The Board can also refuse to conduct a review if it considers the request is unworthy of serious attention.

When the Board agrees to review a complaints panel decision, the College Registrar must provide it with a record of the investigation and the documents and other evidence on which the panel based its decision. The Board must then disclose this information to the two involved parties. However, it can refuse to provide some of this information if it is of the opinion that:

- matters of public security may be involved;
- disclosure of the information could undermine the integrity of the complaint investigation and review process;
- the information is of such a nature that the desirability of not disclosing it outweighs the principle that disclosure should be made;
- that disclosure could prejudice a person involved in a criminal proceeding or civil suit; or
- that disclosure might jeopardize the safety of any person.

The Board may require a College representative to attend review hearings and answer questions, but neither the College representative nor other parties to the hearing (i.e., the complainant or the member) may question one another. The RHPA also allows someone else to represent a complainant at a Board hearing if the complainant dies or becomes incapacitated before the hearing gets underway. This protects the public's interest by ensuring that serious complaints are not withdrawn in these unfortunate situations.

When a review is completed, the Board may do one of the following things:

1. uphold or confirm all or part of a Complaints Committee decision;
2. make recommendations to the Complaints Committee; or
3. require the Complaints Committee to do anything the committee or panel may do under the RHPA.

The third option means, in effect, that the Board can:

- refer an allegation of professional misconduct or incompetence to the College's *Discipline Committee;*
- refer the member to the College's *Executive Committee* for incapacity proceedings; or
- refer the matter to the College's *Quality Assurance Committee* if the complaint is about minor sexual abuse.

The Board must give a written summary of its decisions and reasons for those decisions to both concerned parties and the College's *Complaints Committee.*

Appeals to the Court

The following parties may appeal to the divisional court:

1. a party to a proceeding before the Health Professions Appeal and Review Board concerning a registration review or hearing;
2. a party to a proceeding before a panel of the Discipline Committee; or
3. a party to a proceeding before a panel of the Fitness to Practice Committee (other than an application for reinstatement).

Key Questions Concerning Fairness

Under the provisions of the *Regulated Health Professions Act* (RHPA), regulatory Colleges and the *Health Professions Appeal and Review Board* are given the power to ensure that desired outcomes are achieved. These outcomes include protection from harm, the provision of high quality care and professional accountability. It is important that these powers are exercised in a way that ensures fairness and respect for the rights and interests of all parties. Based on your understanding of these provisions and your own experience, please answer the following questions.

6.1
Have provisions in and implementation of the RHPA been responsive to the barriers faced by diverse and disadvantaged groups in Ontario?

6.2
Have Colleges implemented the requirements of the RHPA in ways that fully respect the rights and interests of potential members, members, complainants and respondents? If not, why not?

6.3
Are the required timeframes for College decisions/actions fair to all concerned parties?

6.4
Does the RHPA provide adequate procedural safeguards, such as checks, balances and appeal provisions?

6.5
Is the process for dealing with complaints sufficiently accessible to the public?

6.6
Are privacy provisions for complainants and respondents (College members) adequate?

6.7
From the point of view of fairness for all, are the powers of the Colleges insufficient, adequate or excessive?

6.8
From the point of view of fairness for all, are the powers of the *Health Professions Appeal and Review Board* insufficient, adequate or excessive?

6.9

Have provisions in and implementation of the RHPA provided the public with access to health professions of choice?

6.10

Has the fact that the RHPA holds all Colleges to the same corporate objectives, public interest standards and governing structures promoted equality among the regulated health professions?

Supplementary Questions

You do not have to answer all or any of the following specific questions. They are provided here mainly to stimulate your thoughts in responding to the above key questions.

6.a.

Does the Complaints and Discipline process meet the needs of both complainants and respondents?

6.b.

Is the average wait between the time of a complaint being made and the time of resolution of the complaint too long?

6.c.

Is the average wait from the time of appeal and the *Health Professions Appeal and Review Board* decision too long?

6.d.

Are the appeal mechanisms outlined in the RHPA insufficient, sufficient or excessive?

6.e.

Does the RHPA strike an appropriate balance between the rights/interests of individual patients/clients and the rights/interests of professional members

6.f.

Should the RHPA clearly define criteria for frivolous and vexatious complaints?

6.g.

Should complainants be given party status at discipline hearings?

6.h.

Is it desirable that third parties be allowed, on behalf of complainants, to bring a complaint in cases where complainants are unable or unwilling to come forward?

6.i.

In addition to the fund for therapy for victims of sexual abuse, should there be provisions in the RHPA for compensation of those who have been harmed by a regulated health professional in the course of receiving health care?

6.j.

Should there be a clearly defined appeal route for decisions of the Executive Committee?

6.k.

Does the RHPA strike an appropriate balance between the powers of the Colleges and the rights/interests of complainants?

6.l.

Does the RHPA strike an appropriate balance between the powers of the Colleges and the rights/interests of professional members?

6.m.

Does the RHPA strike an appropriate balance between the powers of the Colleges pursuant to quality assurance and the rights/interests of health professionals?

Appendix 1 — Review Referral Terms of Reference

Introduction

The *Health Professions Regulatory Advisory Council* (Advisory Council) has been asked by the Minister of Health to undertake a review of the *Regulated Health Professions Act* (RHPA) and related profession-specific Acts five years after enactment. Specifically, the Advisory Council was asked to review the effectiveness and the impact of the RHPA. This referral is called the Review Referral.

In addition to the Minister's initial referral, the Advisory Council has subsequently received two separate ministerial referrals, which were requested by two members of the public (M. Arndt and B. Salvador). While the additional referrals raise different issues, both are concerned with governance issues including the composition of Councils and committees of the Colleges. In both cases, the Minister asked the Advisory Council to consider the issues raised in the context of the Review Referral.

Rationale and History

The Advisory Council initially conducted a number of workshops with the Colleges to solicit input into the nature of the Review. Subsequently, legal input was obtained with respect to a possible framework for the Review. As a result, the Advisory Council has taken the position that the RHPA and the *Health Professions Legislation Review* (HPLR) will be used as complementary sources for objective standards in the Review. (The HPLR was the lengthy process that gave rise to the RHPA; the HPLR document [18] outlines the original policy rationale of the RHPA.)

The Advisory Council has previously recognized that the RHPA has six underlying legislative objectives which further the public interest. These objectives are: protection from harm, promotion of high quality of care, accountability of the professions, access to health care professions of choice, equality among the professions, and equitable treatment of individual patients/clients and professionals. The HPLR included most of these objectives but mentioned other goals of the regulatory scheme as well. Prominent among these, in the Advisory Council's view, are the following three: a balance of power between the regulatory bodies, the patients/clients and the professionals; an efficient and cost-effective system; and a system that, through policy development mechanisms, would be flexible enough to maintain its relevance and usefulness. Thus, one can identify at least nine concepts that can serve as guide-posts for the present Review: protection from harm, quality of care, accountability, accessibility, equality, equity, balance of power, efficiency and flexibility.

18 Schwartz, Alan (Coordinator). Striking a New Balance: A Blueprint For the Regulation of Ontario's Health Professions. Recommendations of the Health Professions Legislation Review. Toronto: Government of Ontario, 1989.

In the context of reviewing the RHPA's effectiveness, the Advisory Council has chosen to focus on the first three of these concepts – protection, quality and accountability. This view follows from a lead in the RHPA itself. Section 6 of the Act outlines the Advisory Council's obligations in reporting on effectiveness in the regulatory system.
The Advisory Council is to report on the effectiveness of specific complaints and discipline processes as well as the quality assurance and patient-relations programs.[19]

In the Advisory Council's view, these statutory effectiveness directives deal most directly with the concepts of protection, quality, and accountability.

It is noted that the Minister asked that both effectiveness and impact be reviewed. In striving to effectively achieve protection, quality and accountability, the Advisory Council recognizes that there could be impacts in the form of financial costs, limited ability to respond to changing professional practices and consumer expectations, and possible encroachment on the interests/rights of various parties under the Act. Thus, the impact of the RHPA will be examined to determine whether these impacts have been minimized, that is, whether efficiency, flexibility and fairness have been achieved. The word "fairness" here embraces the concepts of accessibility, equality, equity and balance of power.

Scope of the Review

Therefore, the Advisory Council will determine whether the RHPA has generated a regulatory system that is effective, efficient, flexible and fair. Further, the Advisory Council will determine the extent to which these achievements are appropriately balanced in relation to each other. Finally, the Advisory Council will advise the Minister accordingly with recommendations for refinement of the regulatory system and amendments to the RHPA.

As mentioned above, the effectiveness of the RHPA will be examined specifically against the legislative objectives of protection from harm, quality of care and accountability of health professionals. Achievement of these objectives is taken as the primary measure of effectiveness. "Achievement" will be determined through input from stakeholders on 1) the extent to which provisions of the RHPA are logically linked to each of these three public interest objectives; 2) the extent to which the regulatory Colleges have been able to implement these provisions of the RHPA, and 3) the extent to which they have implemented the provisions optimally.

The efficiency of the regulatory system will be examined to determine whether the desired objectives of the RHPA are being achieved through reasonable use of time and resources, and whether the administrative burden of regulation can be streamlined without detriment to either the effectiveness, flexibility or fairness of the system.

19 These statutory evaluations have been conducted independently from this Review Referral by external consultants.

As the health care system evolves, through technological advancements for example, the flexibility of the RHPA to address changes in the roles played by individual health professions and in the way individual professions can be utilized is essential. Therefore, the Advisory Council will examine the ease with which the regulatory system has been able to respond to emerging issues in a timely manner.

In the context of the RHPA, fairness is promoted through sensitivity and respect for the interests and rights of all patients/clients and professionals, as well as through unimpeded access and equality among the participants in the regulatory system. Therefore, fairness in the context of this Review, will include such principles.

Process

A series of general and specific questions related to each of the key concepts under review has been prepared by the Advisory Council. However, written responses to these questions will represent only a portion of the research undertaken by the Advisory Council for this Review Referral. Public hearings, focus groups and prevalence studies are also anticipated. Results from the statutory evaluations of the complaints and discipline, quality assurance and patient-relation programs will also become part of this Review.

On the basis of all this information, which will be put on public record, the Advisory Council will determine the extent to which the system is effective, efficient, flexible and fair.

Finally, the Advisory Council will make a judgement as to whether the system's effectiveness and impacts (efficiency, flexibility and fairness) are appropriately balanced in relation to each other. Such is the notion conveyed by the title of this document, ***Weighing the Balance.***

Appendix 2 — Health Regulatory Colleges

College of Audiologists and Speech Language Pathologists of Ontario[20]

College of Chiropodists of Ontario[21]

College of Chiropractors of Ontario

College of Dental Hygienists of Ontario

College of Dental Technologists of Ontario

College of Denturists of Ontario

College of Dieticians of Ontario

College of Massage Therapists of Ontario

College of Medical Laboratory Technologists of Ontario

College of Medical Radiation Technologists

College of Midwives of Ontario

College of Nurses of Ontario

College of Occupational Therapists of Ontario

College of Opticians of Ontario

College of Optometrists of Ontario

College of Physicians and Surgeons of Ontario

College of Physiotherapists of Ontario

College of Psychologists of Ontario

College of Respiratory Therapists of Ontario

Ontario College of Pharmacists

Royal College of Dental Surgeons of Ontario

20 This College regulates two professions: Audiology and Speech Language Pathology.
21 This College also regulates Podiatrists.

Appendix 3 — Controlled Acts

A "controlled act" is any one of the following done with respect to an individual.

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.
2. Performing a procedure on tissues below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surface of the teeth, including the scaling of teeth.
3. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
4. Setting or casting a fracture of a bone or a dislocation of a joint.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger
   - beyond the external ear canal
   - beyond the point in the nasal passages where they normally narrow,
   - beyond the larynx,
   - beyond the opening of the urethra,
   - beyond the labia majora,
   - beyond the anal verge, or
   - into an artificial opening into the body.
7. Applying or ordering the application of a form of energy prescribed by the regulations under this Act (i.e. Regulated Health Professions Act).
8. Prescribing, dispensing, selling or compounding a drug as defined in subsection 117 (1) of the Drug and Pharmacies Regulation Act, or supervising the part of a pharmacy where such drugs are kept.
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
10. Prescribing a hearing aid for a hearing impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.
12. Managing labour or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response (RHPA, section 27).

Appendix 4 — How to Make a Submission

The purpose of this publication is to obtain your input regarding the effectiveness and impact of the *Regulated Health Professions Act*, which came into force on December 31, 1993. The *Health Professions Regulatory Advisory Council*, which is now conducting a five-year review of the Act, will use this input, together with feedback from public hearings and focus groups in making its recommendations to the Minister of Health.

A series of key and supplementary questions appear at the end of Sections I through VI of this publication. Please do not feel obliged to answer all of these questions in preparing your submission—just those which you would like to comment on. If you have any issues that are not addressed by the questions in this document that you would like to speak to, feel free to do so.

Please indicate whether you are making your submission as an individual or on behalf of an organization. Your name, mailing address and telephone number must be included. Anonymous submissions will not be considered.

All submissions must be made in writing. If you have access to a computer, we would also appreciate receiving a diskette copy in Word, Wordperfect or plain text format. You may also send a second copy as an E-Mail attachment to: info@hprac.org.

All submissions will be posted on the Advisory Council's web site (www.hprac.org). This will give individuals and organizations an opportunity to review all submissions. Submissions will be posted as soon as possible after they have been reviewed by the Advisory Council.

Although information posted on the Internet is technically available to a worldwide audience, your identity and privacy will be protected since ***we will not publish the names, addresses or geographic locations of individuals who make submissions.*** This restriction is not applicable to Colleges, associations, organizations or other institutional participants whose addresses are readily accessible in the public domain.

Submissions ***should not include information about individuals or third parties by name.*** To ensure individual and third-party privacy, the Advisory Council reserves the right to delete or amend information that identifies specific health care practitioners, locations or institutions at its sole discretion and without the permission of the submitter.

All submissions must be received the Advisory Council no later than 5:00 p.m. E.S.T. October 29, 1999. A Release Form, which appears on the last page of this publication, must accompany all submissions. Submissions that are not accompanied by a Release Form will not be considered or posted on the Advisory Council's web site.

A copy of this publication is available at your public library.

For additional copies, you may contact:
The Health Professions Regulatory Advisory Council
2195 Yonge St., 4th Floor
Toronto, Ontario M4S 2B2
Phone: 416-326-1550
Fax: 416-326-1549
E-mail: info@hprac.org

The publication can also be viewed on or downloaded from the Advisory Council's website at www.hprac.org.

Copies of the Regulated Health Professions Act, Procedural Code and profession specific acts can be ordered from:

The Government of Ontario Bookstore
Tel: 416-326-5300 or 1-800-668-9938 toll free
TTY: 1-800-268-7095 toll free
or
POOL Publications Ontario On-Line
@http://www.gov.on.ca/mbs/english/publications/

For specific questions about making a submission, you may call:
Tel: 1-888-377-7746 toll free
TTY: 1-800-387-5559

or send an e-mail to: info@hprac.org

Submission Consent and Release Form

Name of Person Making Submission:

Organization Name: (if applicable)

Address:

Phone: (including area code)

E-mail: (if applicable)

I understand that my submission will be posted on the Advisory Council's web site along with all other submissions and hereby give consent to such posting.

Please check the appropriate boxes below:

- ❑ I am making a submission as an individual and understand that my name will not be posted on the web site
- ❑ I am making a submission on behalf of an organization and understand that the name of the organization will be posted on the web site.
- ❑ Although this submission represents the views of an organization, the address listed above is that of an individual and so the address should not be posted on the web site

I have read the instructions in Appendix 4 and understand and agree with the protocols governing submissions and their distribution/posting on the Internet.

I understand that the Advisory Council will review and edit submissions if they contain names or identifiers of third parties.

Signature: **Date:**

Name (please print):

APPENDIX E: REQUESTS RELATED TO NEW CONTROLLED ACTS AND AUTHORITY TO PERFORM CONTROLLED ACTS FROM PROFESSIONS REGULATED UNDER THE *RHPA*

Health Profession Association or College	Requests
Audiology Speech-Language Pathology	• hearing assessment be a controlled act when it is for the purpose of prescribing a hearing aid • the controlled act of prescribing a hearing aid include selecting, verifying or validating a hearing aid • communicate a diagnosis of audiological disorders • communicate oral-pharyngal swallowing disorders diagnosis and communication orders
Chiropody	• communicate a chiropody specific diagnosis • order x-rays
Dental Hygiene	• administer a substance by injection or inhalation • order x-rays • communicate a dental hygiene diagnosis
Dentistry	• Oral maxillofacial surgeons be authorized to: - put an instrument, hand or fingers beyond the external ear canal, the point in the nasal passages where they normally narrow, the larynx, the opening of the urethira, the anal verge, and into an artificial opening into the body. - communicating a diagnosis that be identified from i. the patient health history ii. the findings of a comprehensive health examination, or iii. the results of any laboratory tests other than tests and investigations • expand controlled acts to include the use of lasers and applying drugs
Denturism	• order x-rays • fitting of anti-snoring devices be a controlled act authorized to denturists.
Dietitics	• prescribe therapeutic diets and enteral and parenteral nutrition • exemption from controlled acts to allow dietitians to: - communicate a diagnosis - perform a procedure below the dermis for skin pricking - dispense medical nutrition product samples - administer enteral feeding products

Health Profession Association or College	Requests
Dietitics continued	- prescribe vitamins and/or supplements
Nursing	• communicate a diagnosis • dispense a medication • apply forms of energy (defibrillation, electo coagualtion and trans cutaneous cardiac pacing)
Medical Technology	• new controlled act for medical laboratory quality control procedures • include electrocardiogram as a form of energy in the controlled act
Occupational Therapy	• splinting to be a controlled act authorized to Occupational Therapists
Opticianry	• prescribing glasses and contact lenses using a new computer technology • include dispensing artificial eyes and hearing aids as a controlled act
Pharmacy	• prescribe some drugs under limited, specific protocols • perform diagnostic tests
Physiotherapy	• communicate a diagnosis within the scope of physiotherapy • put an instrument, hand or finger beyond the labia majora and the anal verge • perform a procedure below the dermis
Psychology	• prescribe drugs • controlled acts to include - use of psychological tests - hypnosis - psychotherapy—(distinguished from counselling)
Respiratory Therapy	• apply or order the application of energy in the form of medical gases under high pressure in mechanical ventilation.